



California State Board of Pharmacy

1625 N. Market Blvd, Suite N 219, Sacramento, CA 95834
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STATE AND CONSUMER SERVICES AGENCY
DEPARTMENT OF CONSUMER AFFAIRS
GOVERNOR EDMUND G. BROWN JR.

Date: March 3, 2011

To: Licensing Committee

Subject: Update on the Board's Psychometric Evaluation for the ExCPT and PTCB Examinations

Relevant Statutes

Business and Professions Code section 4202 establishes the requirements for licensure as a pharmacy technician. There are several routes to licensure:

- Obtain an associates degree in pharmacy technology
- Completion of a technician training course
- Graduation from a school of pharmacy recognized by the board
- Certification by the Pharmacy Technician Certification board

Business and Professions Code 139 requires a psychometric assessment description of the occupational analysis serving as the basis for the examination and an assessment of the appropriateness of prerequisites for admittance to the examination.

Background

During the April 2009 Board Meeting, the board voted to direct staff to take the necessary steps to secure a vendor to complete the necessary psychometric assessments of the Pharmacy Technician Certification Board (PTCB) and Exam for the Certification of Pharmacy Technicians (ExCPT).

The results of the review would ensure that these applicants who qualify for licensure as a pharmacy technician have passed a validated exam, consistent with the requirements in B&PC 139. Upon completion, the committee will be advised on the findings at which time it may recommend a change to the statutory requirements for licensure detailed in B&PC 4202.

Last year the board was advised that the department's Office of Professional Examination Services (OPES) will conduct these evaluations for the board which should be completed in June 30, 2011.

Recent Update

Board staff recently signed an interagency agreement with the OPES. It will cost approximately \$24,000.



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STATE AND CONSUMER SERVICES AGENCY
DEPARTMENT OF CONSUMER AFFAIRS
GOVERNOR EDMUND G. BROWN JR.

Date: March 3, 2011

To: Licensing Committee

**Subject: Agenda Item 2-
Discussion Surrounding Dedicated CE**

Pharmacists are required to earn 30 hours of approved continuing education credit every two years as a condition of renewal.

At several prior meetings of the board or its committees, there has been general discussion about developing requirements for pharmacists to earn CE in specific subject matter areas. To establish such a requirement would take either a legislative or regulation change.

Prior discussions have included possible mandatory CE in emergency/disaster response, patient consultation, drug abuse or in maintaining control of a pharmacy's drug inventory. Any topic the board determines as appropriate for mandatory CE should have generally broad-based applicability for pharmacists.

At the February 2011 Board Meeting, the board directed that the committee continue its discussion about such a requirement. Following this memorandum are draft minutes from this section of the board meeting. Also included is information from the Accreditation Council for Pharmacy Education on continuing education for pharmacists.

The specific charge to the Licensing Committee from the board is:

That the board pursue specific content areas for continuing education. If the recommendation is approved, authorize staff to investigate implementation.

At this meeting:

1. Identify Content for Mandatory CE

The committee needs to continue discussion of specific areas of continuing education that it wishes to mandate that all pharmacists should take. The current list of options includes:

- a. Emergency/Disaster Response: Two pharmacy directors of California counties' emergency response teams will attend this meeting to discuss the need for all pharmacists to be trained in emergency response. Dr. Mark Chew (Orange County) and Dr. Glen Tao (Los Angeles) will provide information.
- b. Patient Consultation
- c. Maintaining Control of a Pharmacy's Drug Inventory

- d. Patient Consultation
- e. Ethics
- f. Drug Abuse
- g. Defined Content Areas

The board uses the following areas to construct the CPJE:

I. Patient Medications

- A. Organize and Evaluate Information
- B. Dispense Medications

II. Patient Outcomes

- A. Determine a Course of Action
- B. Educate Patients and Health Care Professionals

III. Pharmacy Operations

- A. Procure Pharmaceuticals, Devices and Supplies, and Control Inventory
- B. Perform Quality Assurance/Improvement
- C. Manage Operations, Human Resources and Information Systems
- D. Manage Medication Use System

- 2. Should the CE be mandated to be Live or Unrestricted in How it is Provided?
- 3. Providing the Coursework (future meeting)

After the committee settles on what subjects and why these subjects are appropriate for mandatory CE, staff will provide options for securing the coursework. These options include:

- a. Specifying the requirements for the training in regulation and then allow any CE provider to provide the course
- b. Releasing a contract of some sort for a vendor to develop and provide the continuing education specified by the board
- c. Developing the course and making it available via the Internet or video
- d. Identifying existing courses in the mandatory content area
- e. Collaborating with the schools to develop the coursework

Draft Minutes: February 1, 2011 Board Meeting Licensing Committee

Excerpt:

c. Summary of a Discussion About a Proposal to Specify Continuing Education Credit for Pharmacists in Specific Content Areas

Mr. Lippe provided that Business and Professions Code section 4231 requires pharmacists to earn 30 hours of approved continuing education credit every two years as a condition of renewal.

He also advised that Business and Professions Code section 4232 establishes the general content of courses, and Article 4 of Division 17 of Title 16, California Code of Regulations, contains the relevant regulations implementing the statutes.

Mr. Lippe stated that at several prior meetings of the board or its committees, including the last two meetings of the Licensing Committee, there was general discussion about developing requirements for pharmacists to earn CE in specific subject matter areas. He stated that to establish such a requirement would take either a legislative or regulation change.

Prior discussions have included the need to earn CE in emergency response, patient consultation or in maintaining control of a pharmacy's drug inventory.

At the October Board Meeting, the board directed that the committee continue its discussion about such a requirement.

Mr. Lippe stated that at December committee meeting there was discussion about the challenges in evaluating whether any CE course is achieving its objective. He stated that the committee also discussed the possibility of breaking the CE requirement into required areas and discretionary subjects and suggested that staff could research providers and possible ways to implement.

The board discussed the recommendation of the Licensing Committee that the board pursue identification of specific content areas for continuing education and to authorize board staff to investigate implementation.

Ms. Veale commented that the Licensing Committee discussion also included mention that specific content areas will aid to better educate licensees for better consumer protection. She discussed that the content areas can change when a need is identified by the board. Ms. Veale discussed that content areas are required by other states.

Dr. Schell provided comment in support of the recommendation. He suggested that the board solicit input regarding content areas from the community, public, and professional organizations.

Public Comment

Dennis McAllister stated that he is familiar with the Accreditation Council for Pharmacy Education's (ACPE) policies, and cautioned the board from being too prescriptive in this area. He suggested that the board review the current ACPE direction regarding continuous professional development.

Michael Negrete, representing the Pharmacy Foundation of California, reiterated the comments made by Mr. McAllister. He suggested that the board also evaluate whether CE should be earned "live" (or in-person).

Ms. Veale asked Dr. Negrete if he is aware of any studies regarding live education.

Dr. Negrete provided that he is unsure of any specific studies. He expressed concern regarding the educational value of written and online programs.

Dr. Castellblanch provided comment in support of live education. He discussed that certain areas of topics are better addressed during a face to face discussion.

Kristy Shellans, DCA Staff Counsel, discussed first amendment challenges to restricting the delivery of education. She stated that education does not necessarily need to be live if it can be delivered in an interactive manner. Ms. Shellans encouraged the board to focus on the interactive aspect of certain elements of education.

Dr. Gray, representing Kaiser Permanente, suggested that the board address the implementation of CE content areas. He recommended that the board consider drug abuse as a CE subject and the establishment of special requirements for pharmacists-in-charge. Dr. Gray discussed the benefits of live education and stated that the Commissions on Education found that the best way to improve education is to require a test after every educational session.

MOTION: LICENSING COMMITTEE: Recommend that the board pursue specific content areas for continuing education. If the recommendation is approved, authorize staff to investigate implementation.

Support: 11 Oppose: 0 Abstain: 0

SOURCE: Excerpted from -- Accreditation Council for Pharmacy Education,
“Accreditation Standards for Continuing Pharmacy Education”
Adopted June 20, 2007, Released October 5, 2007, Effective January 1, 2009

Standard 1: Goal and Mission of the CPE Program

The provider must develop a CPE goal and mission statement that defines the basis and intended outcomes for the majority of educational activities the provider offers.
Guidance

A CPE goal is a concise written statement of what the provider intends to achieve for pharmacy education. The CPE goal should address how a provider will assist pharmacists and technicians* to maintain and enhance their professional competencies to practice in various settings. These may include, but are not limited to:

- ensuring optimal medication therapy outcomes and patient safety,
- managing practice settings,
- satisfying the educational requirements for pharmacist relicensure, and
- meeting recertification requirements for pharmacy technicians.

A CPE mission statement should be consistent with the goals and specifically indicate the provider’s short-term intent in conducting CPE activities, including the intended audience and the scope of activities. The mission and goals should be systematically evaluated and periodically updated to assure consistency among the mission, overall goals, and individual activities.

CPE is a structured educational activity designed to support the continuing professional development of pharmacists and technicians in order to help them maintain and enhance their competence. Each CPE activity should promote problem-solving and critical thinking and be applicable to the practice of pharmacy as defined by the current Definition of Continuing Pharmacy Education (Appendix I).

CPE activities should be designed according to the appropriate roles and responsibilities of the pharmacists and technicians.

Note: The appendices are guides for ACPE-accredited providers as they develop CPE activity content appropriate for pharmacists and technicians.

Standard 2: Educational Needs Assessment

The provider must develop CPE activities based on a multifaceted process where educational needs are prospectively identified.

Guidance

Needs assessment should be completed before planning specific CPE activities and should guide content development and delivery.

A needs assessment should employ multiple strategies to identify the specific gaps in knowledge or skills or areas for enhancement for pharmacists' and technicians' competence. The provider should identify gaps between what pharmacists and technicians do and what is needed and desired in practice.

Strategies for needs assessment should incorporate a method or methods in which representatives of the intended audience participate in identifying their own continuing education needs.

Standard 3: Continuing Pharmacy Education Activities

The provider must structure each CPE activity to meet the knowledge-, application and/or practice-based educational needs of pharmacists and technicians.

Guidance:

Knowledge-based CPE activity: These CPE activities should be designed primarily for pharmacists and technicians to acquire factual knowledge. This information must be based on evidence as accepted in the literature by the health care professions.

The minimum credit for these activities is 15 minutes or 0.25 contact hour.

Application-based CPE activity. These CPE activities should be designed primarily for pharmacists and technicians to apply the information learned in the time frame allotted. The information must be based on evidence as accepted in the literature by the health care professions. The minimum credit for these activities is 60 minutes or one contact hour.

Practice-based CPE activity. These CPE activities should be designed primarily for pharmacists and technicians to systematically acquire specific knowledge, skills, attitudes, and performance behaviors that expand or enhance practice competencies. The information within the practice-based CPE activity must be based on evidence as accepted in the literature by the health care professions. The formats of these CPE activities should include a didactic component and a practice component. The minimum credit for these activities is 15 contact hours.

Providers are not required to offer all three activity types. The CPE activities should be consistent with the provider's mission and appropriate to meet the identified pharmacist and technician needs.

Providers are encouraged to guide pharmacists and technicians to the best combination of CPE activities to meet their practice needs.

Standard 4: CPE Activity Objectives

The provider must develop objectives for each CPE activity that define what the pharmacists and technicians should be able to do at the completion of each CPE activity.

Guidance

Objectives must be:

- specific and measurable
- developed to specifically address the identified educational need (Standard 2)
- addressed by an active learning activity (Standard 7) and
- covered by a learning assessment (Standard 9)

Redesigning Continuing Education for the Health Professions

Lucinda Maine, PhD, RPh
American Association of Colleges of Pharmacy

November 12, 2010



INSTITUTE OF MEDICINE

OF THE NATIONAL ACADEMIES

Advising the nation/Improving health

Committee on Planning for a Continuing Health Care Professional Education Institute

Gail L. Warden (chair)

President Emeritus, Henry Ford Health System

Jako S. Burgers

Senior Researcher, Scientific Institute for Quality of Healthcare

Linda Burnes Bolton

Vice President and Chief Nursing Officer, Cedars-Sinai Medical Center

Catherine DeAngelis

Editor-in-Chief and Senior Vice President, Scientific Publications and Multimedia Applications, JAMA

Robert D. Fox

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Sherry A. Glied

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Kendall Ho

Director, eHealth Strategy Office, Associate Professor, Division of Emergency Medicine, University of British Columbia

Edward F. Lawlor

Dean and William E. Gordon Distinguished Professor, George Warren Brown School of Social Work, Washington University

David Leach

Former Executive Director, Accreditation Council for Graduate Medical Education

Lucinda Maine

Executive Vice President and Chief Executive Officer, American Association of Colleges of Pharmacy

Paul E. Mazmanian

Associate Dean for Continuing Professional Development and Evaluation Studies, Virginia Commonwealth University

Michael W. Painter

Senior Program Officer, Robert Wood Johnson Foundation

Wendy Rheault

Vice President, Academic Affairs, and Dean, College of Health Professions, Rosalind Franklin University of Medicine and Science

Marie E. Sinioris

President and CEO, National Center for Healthcare Leadership

Charge to committee

Review issues in continuing education (CE) of health care professionals to consider the establishment of a national interprofessional CE institute to advance the science of CE

Committee process

- 12 month study
- 3 face-to-face meetings
- 2 public workshops with 17 speakers
- Extensive literature review
- 16 external reviewers

Conclusions about CE

- Purpose of CE is to enable health professionals to keep their knowledge and skills up to date, with the ultimate goal of improving performance and patient outcomes
- CE should be interprofessional and include a broad variety of professionals (e.g., dentists, dieticians, nurses, speech-language pathologists)



Key messages

- There are major flaws in the way CE is conducted, financed, regulated, and evaluated
 - Focus on meeting regulatory requirements rather than identifying personal knowledge gaps
 - Concerns about conflicts of interest in CE activities
 - Regulations that vary widely by profession, specialty, and state, leading to inconsistent learning

Key messages (continued)

- The science underpinning CE is fragmented and underdeveloped
 - Often characterized by didactic learning methods (e.g., lectures) in traditional settings (e.g., auditoriums)
 - Little specific information about how to best support learning
 - Health professionals lack a dependable basis for choosing among CE programs
 - Leaves the larger value of continuing education for health professionals uncertain



Key messages (continued)

- CE should be interprofessional in nature
- A new, comprehensive vision for CE is needed that prepares all health professionals to perform to their highest potential



Toward a system of continuing professional development

- In CPD, learning opportunities:
 - Stretch from the classroom to the point of care
 - Shift control of learning to individual practitioners
 - Adapt to individuals' learning needs
- CPD system offers promise to:
 - Advance evidence-based, interprofessional, team-based learning
 - Strengthen the research workforce, particularly through academic institutions
 - Engender coordination and collaboration among the professions
 - Provide higher quality for a given amount of resources
 - Lead to improvements in patient health and safety



Alternatives considered

- Status quo
- Program within a federal agency (AHRQ or HRSA)
- Purely private structure consisting of professional societies
- Coalition that includes the quality improvement community
- Public-private structure



CPDI

- Independent, public-private body to guide development of national coordinated CPD system
- Budget should depend on exact functions and breadth,
- Standing councils and ad hoc committees to enhance transparency

Recommendation 1: Commission planning of an institute

The Secretary of the Department of Health and Human Services should commission a planning committee to develop a public-private institute for continuing health professional development



Recommendation 1: Commission planning of an institute (continued)

The institute should coordinate and guide efforts in:

- Content and knowledge of CPD
- Regulation across states and professions
- Financing of CPD
(both private and public funds will be needed)
- Strengthening of a scientific basis



Recommendation 2: Envisioning a CPD system

The planning committee should design an institute that:

- a) Creates a new scientific foundation for CPD
- b) Develops, collects, analyzes, and disseminates metrics
- c) Encourages development of health information technology
- d) Encourages development and sharing of improvement tools and theories of knowledge across professions
- e) Fosters interprofessional collaboration
- f) Improves the value and cost-effectiveness of CPD delivery



Recommendation 4: Improve scientific foundation of CPD

The CPDI should lead efforts to improve the scientific foundation of CPD by:

- a) Integrating research methods and findings from all disciplines and professions
- b) Generating research directions to advance understanding of linkage between CPD and patient and population health status
- c) Transforming new knowledge into tools and methods to improve patient care
- d) Promoting the development of measurement instruments to evaluate CPD effectiveness and efficiency



Recommendation 5: Enhance data collection

CPDI should enhance data collection at the individual, team, organizational, system, and national levels, including:

- a) Relating quality improvement data to CPD
- b) Developing national standardized learning portfolios



Recommendation 6: Develop national regulatory standards

The CPDI should work with all stakeholders to develop national standards for regulation of CPD



Recommendation 7: Strengthen financial support

The CPDI should analyze the sources and adequacy of funding for CPD to develop a sustainable business model free from conflicts of interest

(NOTE: The committee expects that with a greater emphasis on quality and patient safety, CPD would be more closely linked to daily operations than is the current case, helping absorb the costs of implementing a CPD system)



Recommendation 8: Foster development of interprofessional models

The CPDI should identify, recognize, and foster models of CPD that build knowledge about interprofessional team learning and collaboration



Recommendation 10: Evaluate progress

The CPDI should report annually to its public and private stakeholders through a national symposium on the performance and progress of professional development and its role in enhancing quality of care and patient safety

For more information about the report and to download the summary:

www.iom.edu/continuinged



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STATE AND CONSUMER SERVICES AGENCY
DEPARTMENT OF CONSUMER AFFAIRS
GOVERNOR EDMUND G. BROWN JR.

Date: March 4, 2011

To: Licensing Committee

**Subject: Agenda Item 3-
Proposal to (Again) Modify 16 CCR Section 1732.2 Regarding
Continuing Education Credit**

Currently undergoing promulgation by the board as a regulation are proposed modifications to 16 California Code of Regulations Section 1732.2 regarding approval of specific continuing education credit for various types of pharmacist activities, including attending a board or committee meeting, being certified by the Commission for Certification in Geriatric Pharmacy or for certain activities as a Competency Committee member. A copy of this pending regulation is provided following this memo. This modified text just completed a 15 day comment period.

Very recently, the executive officer was advised that there are other certifications that some pharmacists earn that perhaps should be considered as fulfilling portions of the CE requirements for renewal of a pharmacist license. If the board determines it wishes to add these components in the future, it will need to be done as a new rulemaking to section 1732.2.

The following were suggested by Professor Katherine Besinque, PharmD, (the requester):

1. Menopause Practitioner Examination- interdisciplinary examination available from NAMS (The North American Menopause Society) (www.menopause.org)
2. Board of Pharmacy Specialties (BPS) has recognized six specialty practice areas: note –these certification examinations also require recertification every 7 years (re-certification by examination should also be permitted for credit) (www.bpsweb.org)
 - [Ambulatory Care Pharmacy](#) (2011)
Includes the provision of integrated, accessible healthcare services by pharmacists who are accountable for addressing medication needs, developing sustained partnerships with patients, and participating in the context of family and community.
 - [Nuclear Pharmacy](#) (1978)
Specialists seek to improve and promote the public's health through the safe and effective use of radioactive drugs for diagnosis and therapy.

- **Nutrition Support Pharmacy** (1988)
Specialists promote the maintenance and/or restoration of optimal nutritional status, designing and modifying treatment according to the needs of the patient.
- **Oncology Pharmacy** (1996)
Specialists recommend, design, implement, monitor and modify pharmacotherapeutic plans to optimize outcomes in patients with malignant diseases.
- **Pharmacotherapy** (1988)
Specialists are responsible for ensuring the safe, appropriate, and economical use of drugs in patient care and frequently serve as a primary source of drug information for other health care organizations.
- **Psychiatric Pharmacy** (1992)
Specialists address the pharmaceutical care of patients with psychiatric disorders.

Dr. Besinque also suggests that:

- as new board specialties are added to BPS they be added to the list.
- re-certification by examination be include as well (re-certification by CE does not need to be included)

Dr. Besinque's request is provided at the end of this section.

Title 16. Board of Pharmacy

Proposed Modified Language

To Amend Section 1732.2. of Article 4 of Division 17 of Title 16 of the California Code of Regulations to read as follows:

1732.2. Board Accredited Continuing Education

(a) Individuals may petition the board to allow continuing education credit hours for specific coursework which is not offered by a provider but meets the standards of Section 1732.3.

(b) Notwithstanding subdivision (a) of this section, coursework which meets the standard of relevance to pharmacy practice and has been approved for continuing education by the Medical Board of California, the California Board of Podiatric Medicine, the California Board of Registered Nursing or the Dental Board of California shall, upon satisfactory completion, be considered approved continuing education for pharmacists.

(c) A pharmacist serving on a designated subcommittee of the board for the purpose of developing the California Practice Standards and Jurisprudence Examination for pharmacists pursuant to section 4200.2 of the Business and Professions Code may annually be awarded up to six hours of continuing education hours for conducting a review of exam test questions. A subcommittee member shall not receive continuing education hours pursuant to this subdivision if that subcommittee member requests reimbursement from the board for time spent conducting a review of exam test questions.

(d) A pharmacist or pharmacy technician who attends a full day board meeting may be awarded up to six hours of continuing education on an annual basis. The board shall designate on its public agenda which day shall be eligible for continuing

Changes made to the regulatory text noticed on October 8, 2010, are indicated as follows:

Deletions to the regulatory text are indicated by double strike-through, thus: ~~deleted language~~.

Additions to the regulatory text are indicated by a double underline, thus: added language.

education credit. A pharmacist or pharmacy technician requesting continuing education hours pursuant to this subdivision must sign in and out on an attendance sheet at the board meeting that requires the individual to provide his or her first and last name, license number, time of arrival and time of departure from the meeting.

(e) A pharmacist or pharmacy technician who attends a full committee meeting of the board may be awarded up to two hours of continuing education on an annual basis. A maximum of four continuing education hours may be earned each year by attending the full meetings of two different board committees. A pharmacist or pharmacy technician requesting continuing education hours pursuant to this subdivision must sign in and out on an attendance sheet at the committee meeting that requires the individual to provide his or her first and last name, license number, time of arrival and time of departure from the meeting.

~~(f) A pharmacist who completes the Pharmacist Self-Assessment Mechanism (PSAM) administered through the National Association of Boards of Pharmacy, may be awarded up to six hours of continuing education.~~

(f) (e) An individual may be awarded three hours of continuing education for successfully passing the examination administered by the Commission for Certification in Geriatric Pharmacy.

Note: Authority cited: Section 4005, Business and Professions Code.
Reference: Sections 4200.2, 4202, 4231 and 4232, Business and Professions Code.

Changes made to the regulatory text noticed on October 8, 2010, are indicated as follows:

Deletions to the regulatory text are indicated by double strike-through, thus: ~~deleted language~~.

Additions to the regulatory text are indicated by a double underline, thus: added language.

Virginia K. Herold

From: Kathy Besinque [Kbesin@pharmacy.usc.edu]
Sent: Tuesday, February 22, 2011 4:24 PM
To: Virginia K. Herold
Subject: Public Comment related to CE and Board Certification programs

Dear Board of Pharmacy

I am writing to make public comment on the proposal below for CE credit for Board Certification. My comments are related to the highlighted section of the proposal only.

I am writing because there are several Board Certification programs within Pharmacy that improve the quality of pharmacist care and contribute to a pharmacists education and training. I propose that these additional Board Certification programs be added to the language in addition to the Geriatric Board Certification exam for CE credit purposes. I would also recommend that as new Board Specialties are added to BPS they be added to the list. I also recommend re-certification by examination be include as well (re-certification by CE does not need to be included)

The following are some of the Board Certification programs I am recommending be considered:

1. Menopause Practitioner Examination- interdisciplinary examination available from NAMS (The North American Menopause Society) (www.menopause.org)
2. Board of Pharmacy Specialties (BPS) has recognized six specialty practice areas: note –these certification examinations also require recertification every 7 years (re-certification by examination should also be permitted for credit) (www.bpsweb.org)
 - **Ambulatory Care Pharmacy** (2011)
Includes the provision of integrated, accessible healthcare services by pharmacists who are accountable for addressing medication needs, developing sustained partnerships with patients, and participating in the context of family and community.
 - **Nuclear Pharmacy** (1978)
Specialists seek to improve and promote the public's health through the safe and effective use of radioactive drugs for diagnosis and therapy.
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Specialists promote the maintenance and/or restoration of optimal nutritional status, designing and modifying treatment according to the needs of the patient.
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Specialists recommend, design, implement, monitor and modify pharmacotherapeutic plans to optimize outcomes in patients with malignant diseases.
 - **Pharmacotherapy** (1988)
Specialists are responsible for ensuring the safe, appropriate, and economical use of drugs in patient care and frequently serve as a primary source of drug information for other health care organizations.
 - **Psychiatric Pharmacy** (1992)
Specialists address the pharmaceutical care of patients with psychiatric disorders.

Thank you,
 Kathleen Hill (Besinque) Pharmacist license #37373
 Associate Professor of Clinical Pharmacy
 USC School of Pharmacy

To Modify Existing Proposed Text and Request for Reconsideration of Prior Board Directive to Initiate a Rulemaking to Amend Title 16 Section 1732.2 – Board Accredited Continuing Education
ATTACHMENT 1

Background

At the February 2010 Board Meeting, the board voted to initiate the rulemaking process to amend 16 CCR § 1732.2. related to board-accredited continuing education. The proposed text was formally noticed for comment on October 8, 2010, and the 45-day comment period concluded on November 22, 2010. The board received one comment in support of the proposed amendments. During the public comment period, the board learned that the National Association of Boards of Pharmacy (NABP) no longer administers the Pharmacist Self-Assessment Mechanism (PSAM). Therefore, subdivision (f) of the proposed amendments is obsolete. The NABP is developing a new self-assessment mechanism, the “PARE” – and the NABP anticipates that the PARE will be available in the 4th quarter of 2011. As initially noticed, the proposed regulation would modify the term “continuing education *credit*” to “continuing education *hours*” and would add board-approved continued education for the following:

- A pharmacist serving on a designated subcommittee for conducting a review of exam test questions (up to 6 hours of CE)
- Attending a full-day board meeting (up to 6 hours annually)
- Attending a full committee meeting (up to 2 hours for each meeting, maximum of four hours annually)
- A pharmacist who completes the PSAM administered by the National Association of Boards of Pharmacy (up 6 hours of CE) [*proposed subdivision (f)*]
- Successfully passing the examination administered by the Commission for Certification in Geriatric Pharmacy (3 hours of CE)



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DEPARTMENT OF CONSUMER AFFAIRS
GOVERNOR EDMUND G. BROWN JR.

Date: March 3, 2011

To: Licensing Committee

**Subject: Update on the Board's Efforts to Implement 16 California Code of Regulations
Section 1702, Mandatory Submission of Fingerprints for Pharmacists**

Relevant Regulations

California Code of Regulations 1701 establishes new renewal requirements for pharmacists.

The regulation specifies that as a condition of renewal, a pharmacist must disclose on the renewal form any arrest or conviction, as specified, since the licensee's last renewal; that a pharmacist applicant must pay the actual cost of compliance with the submission of fingerprints; a requirement that the licensee retain proof of compliance, as specified; and that failure to comply with the fingerprint requirement will result in an application for renewal being considered incomplete. This regulation was approved by the Office of Administrative Law and took effect December 7, 2010.

The board was previously advised that because of staff reductions with the Department of Justice, implementation on the electronic fingerprint submissions would be delayed until the necessary program changes could be implemented. As the necessary changes are now in place, staff is developing letters that will be sent to all affected licensees advising them about the regulation change as well as providing them with the necessary forms. We anticipate mailing this information in April 2011. Pharmacists will be advised to retain a copy of their livescan form or other receipt confirming compliance with this provision.

Implementation of the arrest and conviction disclosure requirements was not delayed.



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GOVERNOR EDMUND G. BROWN JR.

Date: March 4, 2011

To: Licensing Committee

**Subject: Agenda Item 5-
Continuing Competency**

Several months ago, DCA Director Stiger indicated that the Department of Consumer Affairs has an initiative underway to promote that all health care boards initiate periodic assessment of continuing competency in their licensed practitioners.

Continuing competency assessment requires periodic evaluation (and perhaps re-testing) of licensed providers to ensure they are maintaining their skills necessary to practice safely.

In accordance with the Director's request, this item has been added to the committee's agenda. Unfortunately, Director Stiger has been unable to provide specific information he would like us to share with you in this packet. Instead, I am attaching a document prepared last year at the Consumer Advocacy Council's annual meeting.

The committee will have an opportunity to discuss this topic at this meeting.



Assisting public members and the health professional oversight bodies on which they serve

This document contains Friday's proceedings from our 2010 annual meeting, held on Thursday and Friday, November 11 – 12, 2010, in Washington, D.C. Although this is not a verbatim transcript of the speakers' remarks and the question and answer sessions, it is a faithful rendition of what occurred.

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CONTINUING COMPETENCE

INTRODUCTION

Continuing competence is another longstanding priority for CAC. We have been pleased to see recommendations from several prestigious Institute of Medicine committees that advocate more meaningful assessment and demonstration of current competence as a condition of re-licensure and recertification. One such recommendation reads:

All health professions boards should move toward requiring licensed health professionals to demonstrate periodically their ability to deliver patient care, as defined by the five competencies in this report, through direct measure of technical competence, patient assessment, evaluation of patient outcomes and other evidence-based assessment methods.

Other committees have critiqued reliance on mandatory continuing education and recommended significant changes in the way it is delivered. One report we will hear about later this morning is entitled, *Redesigning Continuing Education in the Health Professions*. Part of the justification for this report's recommendations reads:

Licensure and certification processes should reward successful demonstration of maintenance of competence. Additionally, certification should require a minimum standard of practice-based learning to promote the identification and solution of practice-based needs. Licensure should require demonstrated use of learning portfolios with documented needs assessment.

This is not just learning portfolios, but portfolios tailored to an individual's skills, practice and learning needs.

Keynote: The Future of Regulation

Mark Lane, Vice President of Professional Standards and Assessment, Federation of State Boards of Physical Therapy

I'm not going to talk specifically about scope of practice or continued competence, but about regulation in general – what it is, where are we headed, and what can we do about it. Certainly, scope of practice and continuing competence issues play a significant role in the future of regulation.

In order to understand where licensure is heading, we need to understand what licensure is. Here are some things licensure may be:

- **A public policy exercise of the state's police powers.** Is licensure designed to protect the public? Does it protect the public? Or, is it designed to do something entirely different? Is licensure a legalized monopoly to practice a profession? That certainly is an aspect of what licensure is.
- **A system of standards for entry into a profession.**
- **A system of standards for continued practice in the profession.** This raises questions about continued competence.
- **A system for removing impaired or incompetent providers from practice.** How do we identify whom to remove and decide how they should be removed?
- **A legal way to deter entry into a profession.** We may not like it, but licensure does deter entry.
- **A mechanism to protect licensees from competition.** We may not like it, but licensure does do that.
- **A means to gain access to third-party reimbursement.**
- **A means to establish and enhance the prestige of the profession.** We have many professions trying to obtain licensure for status reasons, even when there is no evidence of potential harm to the public.
- **A means to create a market for new academic disciplines.**

There are environmental factors that are influencing the future of regulation:

- **Limited access to healthcare is creating many problems.**
- **Decreasing state budgets which force distorted prioritization by regulators because there aren't the funds to discipline everyone who should be disciplined.**
- **Increasing deficits that force states to cut costs. One way to cut costs is to eliminate licensing boards.**
- **Economic recession, which is helping to drive regulation.**
- **The aging population.**
- **Technology, which changes the ways care is delivered.**

- **Professional associations, which promote their particular agendas and lobby the legislatures.**
- **The public.**
- **National healthcare reform.**

These and other environmental factors compete with each other and regulators are pulled in many different directions. Whoever wins the tug of war will direct the future of regulation.

David Montgomery of the Nebraska Department of Health made a comment I'd like to repeat here:

Our present professional regulatory system is a patchwork resulting from centuries of unsystematic legislation, band-aid fixes, and ad hoc changes. It is marginally effective, but also inefficient, needlessly expensive, inconsistent, and confusing to the public.

Do you agree? Is this true in your experience? If yes, we need to do something about the system. "The best way to predict the future is to invent it," according to Alan Kay, one of the pioneers in computer science. It says we own the future. Our tendency as regulators is to sit back and let things happen to us, but we need to invent the future.

What does it mean to be an inventor? First, we have to change the way we regulate. If we want things to change positively, we can't keep doing the things we have always done. If we want things to get worse, we can sit back and let it happen.

If we are inventors as regulators, what qualities do we need to have?

- **Creativity.** Are we thinking outside the box?
- **Open-mindedness.**
- **Ability to listen.**
- **Willingness to change.**
- **Ability to learn from our mistakes.**
- **Proactivity, rather than reactivity.**
- **Perseverance.**
- **Willingness to question assumptions.**
- **Ability to buck the norm, to ask questions.**

We can all demonstrate these qualities of inventors. We can invent a regulatory future. Public members, licensee members and administrators alike need to stir the pot, to ask questions.

We have two choices. One is to continue on the current regulatory path, allowing things to happen to us. The alternative is to change the face of regulation and be inventors of the future.

What will happen if we stay on the current regulatory path?

- **Continuing scope of practice battles,** where it is the public who loses because decisions aren't based on data. They are based on economics and politics and influence.
- **Reactive regulation.** Should we be regulating in reaction to events, creating a hodge-podge of laws that aren't a cohesive guideline to good practice? Our system is currently complaint-based. This shouldn't be the only determinant of good practice. Moreover,

the complaint system waits until the harm has been done. Shouldn't our approach be to promote good practice so we don't have complaints coming in?

- **Discipline-based regulation.** Does punishment change behavior? Does it work in the public interest?
- **Unenforceable and ineffective regulations.** As an example, most jurisdictions have a supervision ratio for physical therapists vs. physical therapy assistants. The ratio varies from jurisdiction to jurisdiction. It doesn't make sense. What if I am supervising two physical therapy assistants and I get sick or go on vacation? Does that mean the patients cannot get treatment? It's all arbitrary and not based on any evidence. The real concern is whether the physical therapist is a good supervisor, not the ratio. Are our regulations really promoting good care and preventing harm, or are they arbitrary?
- **Little assurance of ongoing clinical competence.** We are at the tip of the iceberg in dealing with continued competence. We are just moving from continuing education to thinking about competence. We are far from impacting and demonstrating competence and influencing patient care.
- **Protection and promotion of the profession.** I hear members of licensing boards and professional associations talk about the battles they are fighting with one or more groups. Why are we talking about battles? Shouldn't we be concerned about the patient and creating a system of regulation and service that is in the best interest of the patient? We need to change the dynamic.
- **Regulation based on assumptions vs. evidence.** Oftentimes our regulations inhibit good practice and may contribute to problems with access.
- **Restriction of mobility.**
- **Lack of collaboration between disciplines.**

What might happen if we do not change our regulatory path?

- **Scope of practice decisions would no longer be made by the professions.** The ideal would be an impartial commission that decides based on what would be best for the public.
- **Boards will be deemed ineffective and be eliminated.** They may be combined, stripped of authority, or nationalized.
- **Continued competence will be mandated and it won't necessarily be a good system.**
- **Licensure requirements will be reduced.**
- **There will be a mandated focus on outcomes.**
- **There will be stricter requirements for sunset review.**
- **There will be an increase in public members and fewer licensee members.**
- **There will be forced licensure compacts to improve mobility within the United States and globally.**
- **Elimination of licensure altogether** if we cannot justify what we are going.

What might happen if we change the face of regulation?

- Interdisciplinary scope of practice decisions.
- Proactive rather than reactive regulation.
- Just Culture, which recognizes that people make honest mistakes.
- Education and promotion of quality, as opposed to just trying to prevent bad care.
- Peer Review.
- Continuing Competence.
- Encourage good practice rather than simply punishing bad practice.

Effective regulation does not inhibit good practice. It is evidence-based. It involves collaboration between disciplines for the greater good. It is proactive. Regulators play an active role in promotion of quality and remediation. Effective continued competence measures are in place. Regulation is part of the solution *vis a vis* access to quality healthcare.

How do we get there?

- **Collect the data.** We are doing a bad job now. We should have the capacity to do data analysis of our licensees to find out what the issues are.
- **Collaborate.** Professions and boards need to work together.
- **Change the framework** from a punitive reactive system to a prevention system.
- **Expand our perspective.**
- **Become inventors.**

Our choices are to continue on our current regulatory path, or to change the face of regulation. I suggest that we work together to do the latter. What leadership competencies would allow us to do this?

- External awareness
- Strategic thinking
- Innovation
- Entrepreneurship
- Leading transformation
- Leadership vs. management

Not everyone on a licensing board will have all these skills. That's why you are a team. Here is another quote from David Montgomery:

As part of healthcare reform, a major national conversation is needed over the effectiveness and efficiency of this system, including licensing, private certification, and enforcement. Such a conversation could lead to reforms that would streamline and modernize licensing practices. At present, there is no sign that this will occur.

It is up to us to change the face of regulation. Invention involves creativity, open-mindedness, willingness to change, learning from our mistakes, being active rather than passive, and perseverance. These are the qualities you need to have on your board to be inventors of the future of regulation.

Is your board made up of inventors? Do your board meetings facilitate invention and the creation of a new future, or do they deal only with the agenda?

I challenge you to create an environment where you help create the future of regulation. We can work together to do that. As Margaret Wheatley wrote,

To be responsible inventors and discoverers, we need the courage to let go of the old world, to relinquish most of what we have cherished, to abandon our interpretations of what does and what does not work. We must see the world anew.

That is our challenge as we deal with scope of practice and continued competence. We need to get out of our comfort zones and start changing the regulatory future.

Comment: There is a provision in the healthcare reform bill saying if a professional gets recertified every two years, he or she is exempt from some data collection.

Comment: In my observation, one of the distinguishing characteristics of effective boards embedded in effective organizations is that there is time set aside for reflective discussion at every board meeting. They challenge the way they do business as a board and the way they do business as an organization. In other words, they exhibit and foster many of the characteristics you mentioned.

How Will the Institute of Medicine's Report "*Redesigning Continuing Education in the Health Professions*" Impact Health Professional Regulatory Boards?

Lucinda Maine, Executive Vice President and CEO, American Association of Colleges of Pharmacy

The work of the IOM Committee on Planning a Continuing Health Care Professional Education Institute needs to be considered together with the work of three other entities. The first of these was research funded by the Macy Foundation. Two key priorities for the Macy Foundation are (1) inter-professional education and (2) maintaining practitioner competence to care for people throughout their professional lifespan. The Macy researchers concluded that the current reliance on continuing education (CE) is insufficient to achieve the second priority. They were particularly concerned about CE in medicine because of what they perceived as commercial biases in its design and delivery. That study group recommended the creation of the IOM committee on which I served and the Macy Foundation provided support.

The Macy Foundation also supported two other pieces of work. One was a study by the Association of American Medical Colleges and the Association of Colleges of Nursing that looked at CE and professional development in those two professions. The fourth piece of work was an economic analysis of the enterprise of CE and continuing professional development.

The IOM committee I served on was charged to review CE of healthcare professionals and to consider specifically a recommendation arising from the first analysis of nursing and medicine to create a national inter-professional continuing education institute to advance the science and the practice of CE.

The committee worked for approximately a year and involved three face-to-face meetings of a very diverse panel. There were two public workshops, extensive literature reviews, and external review of the report and its recommendations.

The committee acknowledged the importance of CE across the lifespan to help professionals stay up-to-date. There was agreement that quality care of the future depends upon the functioning of inter-professional teams. Those teams are going to have different compositions based on practice site and patient needs, but that is the wave of the future. However, we now do uni-rather than multi-professional licensure and certification.

The committee agreed with many others that there are flaws in the way we are currently financing, regulating, conducting and evaluating CE. We agreed that current regulatory requirements are insufficient. There is room for conflicts of interest and bias in the financing CE, but a lot has been done to address this problem.

We talked about the research that is needed to move the enterprise forward. Even though we can draw on the literature on CE and the professions, and we know that the didactic learning method is not optimal for adult learners, we don't know a lot about what more effective models might be, especially for teams of practitioners. We are not currently anywhere near team-based learning at the point of care.

Self-assessment and selecting the right CE program is a very immature science.

The committee embraced continuing professional development as the philosophy and the practice underpinning a better system for keeping our professionals at the cutting edge of their clinical care abilities. The current system is too disaggregated and there is no leverage for change.

We evaluated different scenarios about what could create a better system. One alternative considered was to create a federal agency. Another was a purely private entity composed of professional associations. We considered a coalition involving quality improvement organizations.

Ultimately, we recommended creating a public-private professional development institute that would bring all stakeholders together in support of a nationally coordinated system for professional development. We recommend some initial federal investment, but recognized the need to build a financial model that involves financial support from a variety of sources. The institute would have a board and a structure, but there would also be a variety of councils and ad hoc committees to do the work.

So, our first recommendation was that the Secretary of HHS should commission a planning committee to develop a plan for a public-private continuing professional development institute. This recommendation was made a couple of months before the passage of national healthcare reform, which calls for the creation of multiple offices, agencies and commissions. Our IOM recommendation is likely to take a back seat, but the National Health Workforce Commission called for in the Affordable Care Act could potentially address some of the recommendations in the IOM report.

The institute should help advance what we know about continuing professional development, help to guide and influence regulation across jurisdictions, and professions, address issues associated with financing CE and continuing professional development. The original Macy Foundation report recommending an institute documented the financing of medical CE, but there is little data for other professions. There is also a need for research into the science of CE and professional development.

The goals of the institute include creating a stronger scientific foundation for CE and continuing professional development. This means collecting and analyzing data, or creating a framework for other organizations to conduct data collection, analysis and measurement. Research is needed to identify meaningful measures of practice performance and quality. Electronic health records may facilitate the meaningful measurement of quality in ways we haven't be able to do before.

The committee believed that the institute could help inform regulation nationally, even if regulation continues to be state-based. In pharmacy, there is already a National Association of Boards of Pharmacy and a model pharmacy practice act.

How would continuing professional development be funded? Perhaps employers and practitioners themselves will need to bear more of the expense. Responsibility should be shared by all of the stakeholders.

One of the principal rationales for a national public-private institute is that we are committed to changing the model of patient care to an inter-professional model. Educators have a responsibility to educate future clinicians to work effectively in teams. Early in 2011, pharmacy, medicine, nursing, dentistry and public health will release a set of core competencies for inter-professional education involving these disciplines.

It may be productive to host an annual symposium, perhaps with a partner such as CAC, to synthesize the learning across professionals and energize and advance the enterprise. This would benefit of licensing boards and certifying bodies by assembling a collection of best practices that accelerate learning and improve the delivery of education, the regulation of practice, and the delivery of patient care.

Questioner: I am a public member in the state of Pennsylvania. I am surprised you said there is little research into educational methods other than didactic. Looking at how people on the cutting edge are trained now, some of the techniques are simulation, partial-task training, human patient simulators, gaming, triage scenarios for trauma, virtual reality, joystick-controlled learning, smart phone applications that offer just-in-time training, scenario-based cases, team ratings, video replay, cognitive task analysis, mentoring, and rotating skill stations.

Maine: We talked about everyone of those except the smart phone application, but not in any level of detail. The general consensus was that there is good evidence that there are a variety of different approaches. According to the Department of Education, blended learning appears to be the most effective – i.e., some didactic and some active learning via the tools you mention. Also, online learning appears to be more effective than the traditional model of sitting in a lecture hall and being lectured to. A complicating factor is that many entities that provide active learning are not approved by state regulatory boards so wouldn't satisfy regulatory requirements.

Questioner: There are continuing professional development activities underway within some specialty societies. This is the driver of continuing professional development within the medical professions. There has been a lot of attention paid to the various modalities of CE and other professional development and measurement activities that are part of maintenance of competence. This will undoubtedly be the primary way physicians will demonstrate to licensing authorities and others that they are maintaining their professional competence.

Maine: Maintenance of certification in medicine was on the table as an extremely important model. The problem is that only about three percent of pharmacists are board-certified, so we can't use maintenance of certification the way medicine is using it, and that is true in other disciplines also.

Questioner: Professional development must take place in the practice setting and not in a lecture hall. Mandatory CE is a big source of resort and cruise business in the US. Boards are asking people for contact hours, with little attention to the content of those hours. Did the committee address the role of licensing boards as the demand structures to drive the desired change?

Maine: It was clearly understood that state mandates for CE units are the leading driver of practitioner behavior today. Most licensed professionals have those requirements. Nobody knows what would happen if they went away and nobody is recommending that the requirements and the regulatory oversight go away. But, we did talk about the probability that workplace learning is the most effective model.

Questioner: Please elaborate on the topic of funding by private sources, particularly with respect to pharmaceutical companies, which I think are pernicious when I see their ads on television. What circumstances would make it okay for pharmaceutical companies to be funding CE?

Maine: I agree. There is a difference between marketing activities, which are regulated by the FDA (including all the pernicious advertising on TV) and continuing education grant support. I administered CE

earlier in my career and AACP offers CE credits at our annual meetings. I think the point made by the economist on the IOM committee was that there is absolutely potential for wrongdoing and ample evidence of it occurring, but if the accreditation framework for the providers of CE and the regulatory framework for the consumers of the CE have adequate safeguards, then wrongdoing shouldn't occur. The situation has improved and many providers have left the business. There has been some creative thinking, for example, finding ways to demonstrate that what is learned in CE is applied to patient care.

Comment: I am the current President of the National Board for the Certification of Hospice and Palliative Care Nurses and the President of the Alliance of Hospice and Palliative Nursing. My comment goes to the recommendation related to inter-professional models. We are very proud that the American Academy of Hospice and Palliative Physicians and the Hospice and Palliative Nurses Association have a combined conference every year. The conference includes social workers, physicians, registered nurses, administrators, nursing assistants, and advanced practice nurses. They not only attend, they are also presenters. All the professions benefit from the presentations and the networking that goes on.

Maine: The Society of Critical Care Medicine is another organization that is moving in that same direction. We need to foster this kind of collaboration and to find ways to make the documentation of CE as inter-disciplinary and user-friendly as possible.

Comment: I am a public member of a medical board and a public member of the Accreditation Council for Continuing Medical Education (ACCME). As a sociologist, I am very skeptical about pharmaceutical companies and am suspicious of the research they fund. However, one of the things that ACCME has done is to require in its accreditation standards at least a symbolic separation between pharmaceutical company funding and what is actually taught in CE courses and the faculty who does the teaching. ACCME is also working with nursing organizations to permit both physicians and nurses to earn CE credit for some of the same courses. The proposed institute seems a great way to encourage more of this kind of collaboration.

Comment: I am with the Wyoming State Board of Nursing. We have been struggling with competence for initial licensure for entry-level nurses. We approve education programs and approve many online programs because of the rural nature of the state. Our requirement for practical clinical experience for initial licensure has provoked a lot of political pushback against online programs. We rely heavily on the National Council of State Boards of Nursing's research, which shows that practical experience with a preceptor in an educational setting must supplement online learning.

Continuing Competence Initiatives by Licensing Board Associations

Martin Crane, Immediate Past Chair, Federation of State Medical Boards Board of Directors

The goal of the maintenance of licensure initiative at the Federation of State Medical Boards (FSMB) is to assure the continued competence of licensed physicians. This effort has moved forward in a deliberate and thoughtful fashion for about six or seven years.

Maintenance of licensure is a sea change in the licensure and license renewal process for physicians. It will mean that, as a condition of licensure renewal, physicians must demonstrate participation in a continuous professional development program of life-long learning that is objective, practice-relevant, and results in demonstrable practice improvement over time. It is the kind of change that the Institute of Medicine (IOM) has been recommending.

Why do it? Because state medical boards are mandated to protect the public and guarantee that licensed physicians are competent. It is implied authority in every medical practice act. For physicians, it is a commitment to their patients. For the public, it is an assurance that they have access to the highest quality care. I believe it will give the public confidence in a self-regulatory system and the medical profession. We are preparing to launch the initiative in a few states in the near future and expect full implementation in five to ten years.

Assuring that physicians maintain their competence throughout their careers is an absolute expectation by the public. Most surveys show that the public already believes that physicians are periodically evaluated for competence and quality of care.

The initial licensing process takes into account education, training, experience, examination, and other factors. The re-licensure process to date has been mainly administrative. I agree with the previous speaker that mandatory continuing education leaves a lot to be desired, at least the continuing education system we have now.

There is definitely a cultural and paradigm shift underway in medicine and some other professions away from the reactive, complaint-driven approach to a proactive approach of prevention and improvement. This is not about finding bad apples. It is about making good practitioners better by encouraging continuing professional development.

We paid attention to the IOM reports (*To Err is Human*, *The Quality Chasm*, etc.), the Pew Commission recommendations, the patient safety and error reduction movements and recognized that the accountability of the regulatory system was being challenged. We did not want to be part of the problem and felt that we could change and be part of the solution.

We created a special committee, which included representatives of the public, the IOM and other stakeholders in addition to medicine. The core statement of this effort is that medical boards have an obligation to the public to ensure the ongoing competence of physicians seeking license renewal. This is the same as their obligation to assess people seeking initial licensure.

An important point about the recommendations coming from the committee is that current competence needs to be demonstrated within the scope of one's daily professional practice. We began with the core competencies of the Accreditation Council for Graduate Medical Education (ACGME), which encompass most of the practice of medicine and pay attention to system-based and team approaches to practice. This is a non-punitive, non-burdensome system for physicians and does not create undue expectations by the public.

The guiding principle is lifelong learning to facilitate improvement in practice. State boards establish the requirements, but they don't have the resources and funding to do everything, so they will collaborate with other organizations, such as assessment certification organizations and third-party attestations, just as the CE process does now. The system should not compromise care nor create barriers to physician practice. It needs to balance transparency and privacy.

We created an advisory group in 2009 to look at the impact FSMB has on boards, on the public, on physicians, to review the FSMB's reports, to predict the challenges in the future, and to decide whether the maintenance of licensure initiative is a value-added endeavor. The advisory group represented regulators, licensees, legislators, assessment certification bodies, and the public. It endorsed the concept that licensees must participate in a professional development program based on the ACGME competencies.

There are three components to implementation: Objective self-assessment of knowledge and skills; performance improvement plans, measurement of the resulting improvements. Licensees may choose from several options to satisfy these three requirements.

One option is to maintain specialty certification, which itself requires continuing professional development and continuous practice improvement. About seventy percent of physicians are board-certified. That leaves at least thirty percent who cannot maintain their licenses through that route.

There are also physicians who are grandfathered by their specialty certification boards, which means they are exempt from maintenance of certification requirements. Depending on the specialty, anywhere from 29 – 40 percent of physicians are grandfathered. There are also physicians who choose not to re-certify – 29 percent of generalists.

So, more than half physicians cannot participate in maintenance of certification as a surrogate for maintenance of licensure.

The system needs to be verifiable and satisfy the public that the profession means business. It needs to cover physicians who are in non-clinical roles because they may want to re-enter practice in the future.

In April, FSMB approved a framework for maintenance of licensure and a template for state board implementation. This will be exposed for public comment, submitted to the board in February and to the FSMB delegate assembly in April 2011.

The startup plan allows boards to build on programs they already have, so long as they are consistent with continuing professional development and lifelong learning, and do not rely exclusively on CE. We anticipate that the program will evolve with time. Self-assessment will drive educational opportunities and improvement plans will drive practice changes. We will start with a renewal cycle of 5-10 years

Challenges remain. One is that we are still developing programs like this in silos. We still don't fully know how we will deal with non-clinically active physicians.

We don't want to push out physicians who are at the end of their careers. Reciprocity and portability among states is important. Remediation programs must be created for those whose self-assessment identifies deficiencies.

FSMB is happy to share what we are doing as a model for other professions.

William Rafferty, Immediate Past President, Association of Regulatory Boards of Optometry

I am here on behalf of the Association of Regulatory Boards of Optometry (ARBO), but I am presenting as myself today because I don't know whether my board would support everything I say.

Regulatory boards are charged with responsibility for ensuring the competence of licensees. Currently continuing education is the modality optometry uses. I think we all know that is insufficient.

ARBO formulated a plan based on common sense, which looks a lot like what the FSMB is doing. It is a work in progress. Our continuing education program (COPE) categorizes continuing education into subject areas and creates a framework states can use. It includes an accreditation process and a tracking system for every optometrist in the country. We also have a national mobility program providing a national uniform high standard for mobility. It has not been adopted by many states.

We have been working on competency since the 1960s, when we developed our CE system. Recently, we have had conferences on the topic. In 2009 we conducted a survey, which asked whether general board certification and continued competence are the same. Seventy-three percent of respondents said they are not the same. We asked whether there is a need for track education programs with post-assessment. Most respondents thought so. We asked them to name the highest priority for regulatory boards at this time. More than 50 percent said continued competence. This gave us the momentum to pass a resolution supporting the development of an improved system for demonstrating continued competency for the benefit of the public. In 2010, we presented the outline of our competency program to the membership. It was fairly well received.

Yesterday, our board considered increasing the number of CE hours and adding a test at the end. I said I thought that would be doing more of the same and expecting a different outcome. That approach would still not identify the practitioner's weaknesses and it would not demonstrate the practitioner's competence to the public. I believe those are the two objectives we must try to accomplish. Hopefully, we will modify our approach in North Carolina.

People ask why bother to have a continuing competence program? Healthcare consumers have a right to expect their practitioner is competent. Our maintenance of licensure concept was not designed for third parties; it is designed to protect the public. However, we recognize that in some professions, competence will be demonstrated through certification and in others through licensure.

Our plan uses the competency, accreditation, and tracking programs I mentioned earlier. It involves self-assessment. It involves putting a framework around both continuing education and continuing professional development to address the results of self-assessment. It includes a post-assessment component to monitor what happens in step two and identify changes that affect practice performance. We want to see long-term changes in practice.

The self-assessment is computer-based. It can be self-or testing center-administered. It is not a test, but a self-assessment module. It directs education and remediation to an individual's weaknesses, not their strengths. Practitioners will be provided feedback about strengths and weaknesses.

The curriculum attempts to establish a dynamic, well-rounded, long-term learning process. Because optometry is a specialized area, it is possible to break down the learning process according to sections of the eye. There can be required areas and elective areas and general requirements related to ethics and medical errors, and so on.

Continuing professional development includes accredited and non-accredited learning activities, self-assessment programs, structural learning, degree programs, chart review, teaching, research, and so on. The post-assessment component is designed to determine the effectiveness of the educational and professional development activities. We are thinking of a five-year framework for pre- and post-assessment.

This program could fit well in most states without statutory modifications. It is designed for boards that want to enhance their current programs. The program is feasible for ARBO because it builds on existing programs, such as the data tracking.

Questioner: Please talk a bit about the concepts of "legally defensible and psychometrically sound." These are often raised as stumbling blocks in the way of continued competence programs.

Crane: The American Board of Medical Specialties first called its program "maintenance of competence." Early on, they learned that they would not be indemnified if they gave someone a certificate of competence, so they changed the name to maintenance of certification. FSMB researched this and learned that we are indemnified and can use the word competence. The legal concerns you raise vary from jurisdiction to jurisdiction.

Rafferty: Our plan is to start small, with two or three states, to see what problems we run into. We are fortunate to have an exceptional psychometrically sound testing agency, which will be used for self-assessment and post-assessment, so it will be legally defensible.

Questioner: The Accreditation Council for Pharmacy Education accredits providers of continuing education. Quality improvement in CE is part of our strategic plan. Dr. Crane, you mentioned that non-clinically active physicians and physicians with inactive licenses will have to comply. Please explain how that will work.

You also referred to maintenance of competence programs in other countries, which have moved toward a continuing professional development model. In pharmacy, most of these countries have a split register. They have different requirements for maintenance of licensure for pharmacists who are clinically active and those who are not. Please comment on this, given the objective of having a competency system that relates to what practitioners do on a daily basis.

Crane: There is a difference between having an active license and being an active physician. Anyone with an active license has to go through an administrative renewal process currently. Some of the licensees are not in clinical practice. They may be in administrative roles. There is a movement to create an administrative license, which would not authorize an individual to practice, but would enable him or her to be a medical director of an HMO or hospital.

Those with inactive licenses must now demonstrate something to a medical board in order to gain an active license. In the future, anyone who decides to re-enter practice will have to satisfy the maintenance of licensure requirements.

We were sure from the start that what we were talking about was an individual's current daily practice. We are now looking into the idea of "mapping a practice," as is currently done in hospitals. Most of medicine is now practiced outside hospitals.

Questioner: Do you have a system worked out for monitoring compliance with your program?

Rafferty: The program could be voluntary initially, but we are hoping state boards will adopt the program for re-licensure. In North Carolina, we monitor 100 percent of CE compliance currently, and could monitor a new program the same way.

Crane: Currently, medical boards randomly monitor CMEs. So, we don't really know much about compliance right now. We thought we would start with an attestation system because boards don't have the resources to monitor. Ultimately, in order to be credible, the system has to be verifiable. I am hoping that we will incentivize participation with changes in the reimbursement process.



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STATE AND CONSUMER SERVICES AGENCY
DEPARTMENT OF CONSUMER AFFAIRS
GOVERNOR EDMUND G. BROWN JR.

Date: March 3, 2011

To: Licensing Committee

**Subject: Office of Statewide Health Planning and Development's Manpower
Assessment and Survey of Licensees**

Background

As part of Senate Bill 139 (Chapter 522, Statutes of 2007) the Office of statewide Health Planning and Development (OSHDP) was directed to establish the California Healthcare Workforce Clearinghouse (Clearinghouse) to serve as the central source for collection, analysis, and distribution of information on the healthcare workforce employment and educational data trends for the state.

Specifically the bill included a provision that OSHDP work with the Employment Development Department's Labor Market Information Division, state licensing boards, and state higher education entities to collect, to the extent available, all of the following data:

- (a) The current supply of health care workers, by specialty.
- (b) The geographical distribution of health care workers, by specialty.
- (c) The diversity of the health care workforce, by specialty, including, but not necessarily limited to, data on race, ethnicity, and languages spoken.
- (d) The current and forecasted demand for health care workers, by specialty.
- (e) The educational capacity to produce trained, certified, and licensed health care workers, by specialty and by geographical distribution, including, but not necessarily limited to, the number of educational slots, the number of enrollments, the attrition rate, and wait time to enter the program of study.

Issue

Acting Director Brian Stiger is encouraging all boards to collect the necessary information to assist OSHDP in their charge to, among other items, serve as the repository for comprehensive data and standardize data collection tools and methods.

Many of the boards within the DCA, including our board do not collect several of the data elements being requested by OSHDP. The Medical Board developed a survey that is designed to collect several elements. The survey is provided to licensees along with their renewal application. It is our understanding that the results will be provided to OSHDP.

Staff Recommendation

As mandating submission of this information would require either a regulation and/or statutory change, board staff recommends that the board consider development of a survey that could be accessed from the board's web site. An on-line resource such as Survey Monkey, could serve as an easy collection method that would have minimal impact on board staff.

Following this memo is a copy of a fact sheet on the Healthcare Workforce Clearinghouse as well as the draft survey that will be used by the Medical Board.

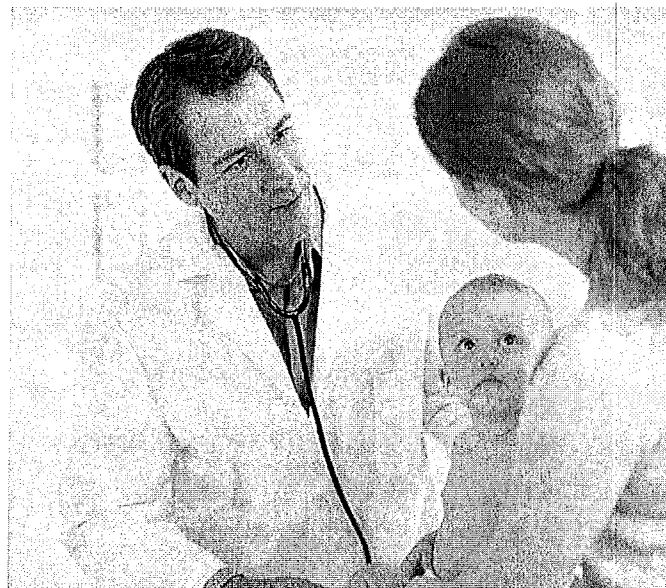
CLEARINGHOUSE

Establishment of the Clearinghouse will enhance California's ability to understand and manage its complex healthcare delivery infrastructure and growing and aging population.



HWDD MISSION

The Healthcare Workforce Development Division promotes healthcare workforce development, distribution, diversity, competency, collaboration and capacity building to accommodate healthcare service requirements, within California's various health delivery settings, today and tomorrow.



State of California
Office of Statewide Health Planning
and Development
400 R Street, Suite 330
Sacramento, California 95811
(916) 326-3700
www.oshpd.ca.gov/hwdd



October 7, 2010

Factsheet

Healthcare Workforce
Clearinghouse

**WANT
DATA?**

oshpd

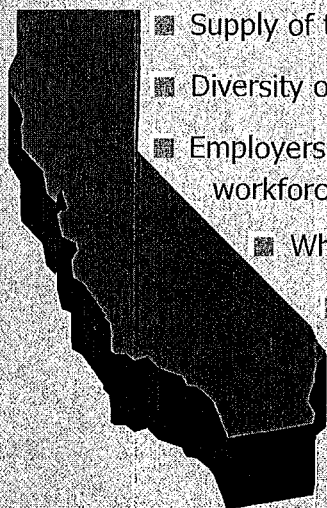
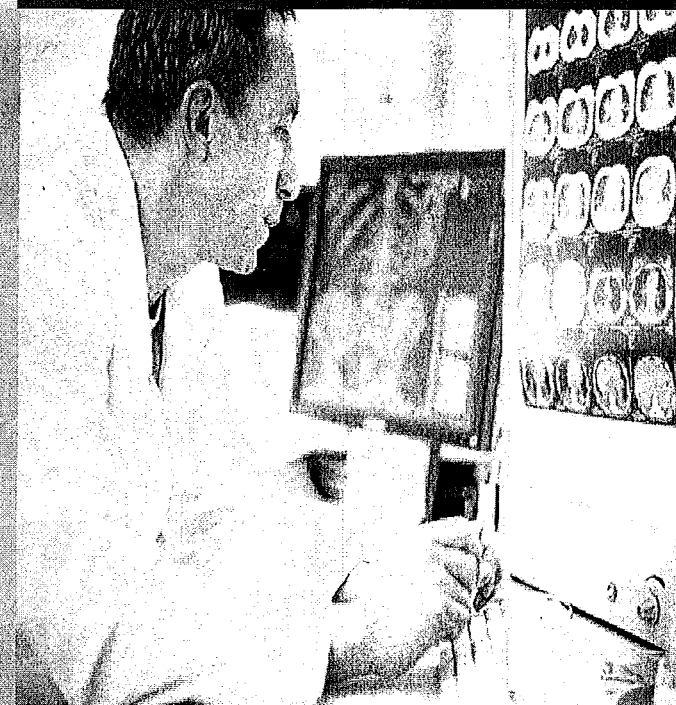
WHAT IS HEALTHCARE WORKFORCE AND FACULTY DATA?



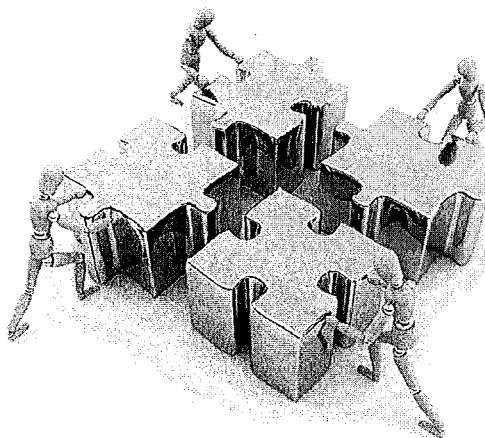
WHO ARE THE STATUTORY DATA PROVIDERS?

- Employment Development Department's Labor Market Information Division
- 22 health licensing authorities
- University of California Office of the President
- California State University Chancellor's Office
- California Community Colleges Chancellor's Office
- Office of Statewide Health Planning and Development

WHAT ARE THE BENEFITS?



- Supply of the workforce
- Diversity of the workforce
- Employers' current and projected workforce demand
- Where they are working
- Educational capacity to train workers
- Student enrollment and graduates



- Centralize comprehensive data
- Conduct trend analysis and reporting
- Standardize data collection tools and methods
- Improve workforce recruitment and retention
- Disseminate data easily
- Develop policy and planning strategies
- Address workforce shortages

MAIL-IN PHYSICIAN RENEWAL SURVEY

Complete in Black or Blue Ink
Shade Circles Like This ●

Mail-In Physician Survey

Return to MBC

Date Survey Completed MM/DD/YYYY

--	--	--	--	--	--	--	--	--	--

License Type/Number: str005 int006str007
Expiration Date: dte014

Are you retired?

☐ Yes ☐ No

If yes, skip to #9.

1. ACTIVITIES IN MEDICINE

Mandatory: Fill in one circle on each line.

Hours	None	1-9	10-19	20-29	30-39	40+
Patient Care	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Telemedicine	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Administration	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Research	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Teaching	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Other	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

2. PRACTICE LOCATIONS

Mandatory: If you have hours for Patient Care, enter the primary and secondary practice location(s).

Primary practice location (U.S. Only)		Secondary practice location (U.S. Only)	
Zip Code	County Code	Zip Code	County Code
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

CODES (CA County / Out of State)

01 Alameda	11 Glenn	21 Marin	31 Placer	41 San Mateo	53 Trinity
02 Alpine	12 Humboldt	22 Mariposa	32 Plumas	42 Santa Barbara	54 Tulare
03 Amador	13 Imperial	23 Mendocino	33 Riverside	43 Santa Clara	55 Tuolumne
04 Butte	14 Inyo	24 Merced	34 Sacramento	46 Sierra	56 Ventura
05 Calaveras	15 Kern	25 Modoc	35 San Benito	47 Siskiyou	57 Yolo
06 Colusa	16 Kings	26 Mono	36 San Bernardino	48 Solano	58 Yuba
07 Contra Costa	17 Lake	27 Monterey	37 San Diego	49 Sonoma	
08 Del Norte	18 Lassen	28 Napa	38 San Francisco	50 Stanislaus	98 Out of State
09 El Dorado	19 Los Angeles	29 Nevada	39 San Joaquin	51 Sutter	
10 Fresno	20 Madera	30 Orange	40 San Luis Obispo	52 Tehama	

3. CURRENT TRAINING STATUS

Mandatory: ☐ Residency ☐ Fellow ☐ Not in Training

4. MEDICAL PRACTICE/SPECIALTY AND BOARD CERTIFICATIONS

Mandatory: Mark all of your specialty classifications in your primary (P) and secondary (S) practice areas. Also, mark any Board Certifications (BD) that you have.

P	S	BD Certification	P	S	BD Certification
<input type="radio"/>	<input type="radio"/>	Addiction Psychiatry	<input type="radio"/>	<input type="radio"/>	General Practice
<input type="radio"/>	<input type="radio"/>	Adolescent Medicine	<input type="radio"/>	<input type="radio"/>	Geriatric Medicine
<input type="radio"/>	<input type="radio"/>	Advanced Heart Failure and Transplant Cardiology	<input type="radio"/>	<input type="radio"/>	Geriatric Psychiatry
<input type="radio"/>	<input type="radio"/>	Aerospace Medicine	<input type="radio"/>	<input type="radio"/>	Gynecologic Oncology
<input type="radio"/>	<input type="radio"/>	Allergy and Immunology	<input type="radio"/>	<input type="radio"/>	Hematology
<input type="radio"/>	<input type="radio"/>	Anatomic Pathology and Clinical Pathology	<input type="radio"/>	<input type="radio"/>	Hospice and Palliative Medicine
<input type="radio"/>	<input type="radio"/>	Anesthesiology	<input type="radio"/>	<input type="radio"/>	Infectious Disease
<input type="radio"/>	<input type="radio"/>	Blood Banking/Transfusion Medicine	<input type="radio"/>	<input type="radio"/>	Internal Medicine
<input type="radio"/>	<input type="radio"/>	Cardiovascular Disease	<input type="radio"/>	<input type="radio"/>	Interventional Cardiology
<input type="radio"/>	<input type="radio"/>	Child Abuse Pediatrics	<input type="radio"/>	<input type="radio"/>	Maternal and Fetal Medicine
<input type="radio"/>	<input type="radio"/>	Child and Adolescent Psychiatry	<input type="radio"/>	<input type="radio"/>	Medical Biochemical Genetics
<input type="radio"/>	<input type="radio"/>	Clinical and Laboratory Dermatological Immunology	<input type="radio"/>	<input type="radio"/>	Medical Genetics
<input type="radio"/>	<input type="radio"/>	Clinical Biochemical Genetics	<input type="radio"/>	<input type="radio"/>	Medical Oncology
<input type="radio"/>	<input type="radio"/>	Clinical Cardiac Electrophysiology	<input type="radio"/>	<input type="radio"/>	Medical Toxicology
<input type="radio"/>	<input type="radio"/>	Clinical Cytogenetics	<input type="radio"/>	<input type="radio"/>	Molecular Genetic Pathology
<input type="radio"/>	<input type="radio"/>	Clinical Genetics (MD)	<input type="radio"/>	<input type="radio"/>	Neonatal-Perinatal Medicine
<input type="radio"/>	<input type="radio"/>	Clinical Molecular Genetics	<input type="radio"/>	<input type="radio"/>	Nephrology
<input type="radio"/>	<input type="radio"/>	Clinical Neurophysiology	<input type="radio"/>	<input type="radio"/>	Neurodevelopmental Disabilities
<input type="radio"/>	<input type="radio"/>	Colon and Rectal Surgery	<input type="radio"/>	<input type="radio"/>	Neurological Surgery
<input type="radio"/>	<input type="radio"/>	Complementary and Alternative Medicine	<input type="radio"/>	<input type="radio"/>	Neurology with Special Qualification in Child Neurology
<input type="radio"/>	<input type="radio"/>	Congenital Cardiac Surgery	<input type="radio"/>	<input type="radio"/>	Neurology
<input type="radio"/>	<input type="radio"/>	Cosmetic Surgery	<input type="radio"/>	<input type="radio"/>	Neuromuscular Medicine
<input type="radio"/>	<input type="radio"/>	Critical Care Medicine	<input type="radio"/>	<input type="radio"/>	Neuropathology
<input type="radio"/>	<input type="radio"/>	Cytopathology	<input type="radio"/>	<input type="radio"/>	Neuroradiology
<input type="radio"/>	<input type="radio"/>	Dermatology	<input type="radio"/>	<input type="radio"/>	Neurotology
<input type="radio"/>	<input type="radio"/>	Dermatopathology	<input type="radio"/>	<input type="radio"/>	Nuclear Medicine
<input type="radio"/>	<input type="radio"/>	Developmental-Behavioral Pediatrics	<input type="radio"/>	<input type="radio"/>	Nuclear Radiology
<input type="radio"/>	<input type="radio"/>	Diagnostic Radiology	<input type="radio"/>	<input type="radio"/>	Obstetrics and Gynecology
<input type="radio"/>	<input type="radio"/>	Emergency Medicine	<input type="radio"/>	<input type="radio"/>	Occupational Medicine
<input type="radio"/>	<input type="radio"/>	Endocrinology, Diabetes and Metabolism	<input type="radio"/>	<input type="radio"/>	Ophthalmology
<input type="radio"/>	<input type="radio"/>	Facial, Plastic and Reconstructive Surgery	<input type="radio"/>	<input type="radio"/>	Orthopaedic Sports Medicine
<input type="radio"/>	<input type="radio"/>	Family Medicine	<input type="radio"/>	<input type="radio"/>	Orthopaedic Surgery
<input type="radio"/>	<input type="radio"/>	Forensic Psychiatry	<input type="radio"/>	<input type="radio"/>	Otolaryngology
<input type="radio"/>	<input type="radio"/>	Gastroenterology	<input type="radio"/>	<input type="radio"/>	Pain Medicine
			<input type="radio"/>	<input type="radio"/>	Pathology - Anatomic

Continued on reverse side

P	S	BD Certification
<input type="radio"/>	<input type="radio"/>	<input type="radio"/> Plastic Surgery Within the Head and Neck
<input type="radio"/>	<input type="radio"/>	<input type="radio"/> Psychiatry
<input type="radio"/>	<input type="radio"/>	<input type="radio"/> Psychosomatic Medicine
<input type="radio"/>	<input type="radio"/>	<input type="radio"/> Public Health and General Preventive Medicine
<input type="radio"/>	<input type="radio"/>	<input type="radio"/> Pulmonary Disease
<input type="radio"/>	<input type="radio"/>	<input type="radio"/> Radiation Oncology
<input type="radio"/>	<input type="radio"/>	<input type="radio"/> Radiologic Physics
<input type="radio"/>	<input type="radio"/>	<input type="radio"/> Radiology
<input type="radio"/>	<input type="radio"/>	<input type="radio"/> Reproductive Endocrinology/Infertility
<input type="radio"/>	<input type="radio"/>	<input type="radio"/> Rheumatology
<input type="radio"/>	<input type="radio"/>	<input type="radio"/> Sleep Medicine
<input type="radio"/>	<input type="radio"/>	<input type="radio"/> Spinal Cord Injury Medicine
<input type="radio"/>	<input type="radio"/>	<input type="radio"/> Spine Surgery
<input type="radio"/>	<input type="radio"/>	<input type="radio"/> Sports Medicine
<input type="radio"/>	<input type="radio"/>	<input type="radio"/> Surgery
<input type="radio"/>	<input type="radio"/>	<input type="radio"/> Surgery of the Hand
<input type="radio"/>	<input type="radio"/>	<input type="radio"/> Surgical Critical Care
<input type="radio"/>	<input type="radio"/>	<input type="radio"/> Surgical Oncology
<input type="radio"/>	<input type="radio"/>	<input type="radio"/> Thoracic Surgery
<input type="radio"/>	<input type="radio"/>	<input type="radio"/> Transplant Hepatology
<input type="radio"/>	<input type="radio"/>	<input type="radio"/> Undersea and Hyperbaric Medicine
<input type="radio"/>	<input type="radio"/>	<input type="radio"/> Urology
<input type="radio"/>	<input type="radio"/>	<input type="radio"/> Vascular and Interventional Radiology
<input type="radio"/>	<input type="radio"/>	<input type="radio"/> Vascular Neurology
<input type="radio"/>	<input type="radio"/>	<input type="radio"/> Vascular Surgery
<input type="radio"/>	<input type="radio"/>	<input type="radio"/> Other - Not Listed

6. RACE / ETHNIC BACKGROUND *Select one or more that best describes your race / ethnic background.*

7. FOREIGN LANGUAGES / DIALECTS *In addition to English, indicate additional languages in which you are fluent.*

<input type="radio"/> African Languages	<input type="radio"/> Hebrew	<input type="radio"/> Other Sign Language	<input type="radio"/> Telugu
<input type="radio"/> American Sign Language	<input type="radio"/> Hindi	<input type="radio"/> Mon-Khmer (Cambodian)	<input type="radio"/> Thai
<input type="radio"/> Amharic	<input type="radio"/> Hmong	<input type="radio"/> Navajo	<input type="radio"/> Tongan
<input type="radio"/> Arabic	<input type="radio"/> Hungarian	<input type="radio"/> Panjabi (Punjabi)	<input type="radio"/> Turkish
<input type="radio"/> Armenian	<input type="radio"/> Ilokano	<input type="radio"/> Persian (Farsi)	<input type="radio"/> Ukrainian
<input type="radio"/> Cantonese	<input type="radio"/> Indonesian	<input type="radio"/> Polish	<input type="radio"/> Urdu
<input type="radio"/> Croatian	<input type="radio"/> Italian	<input type="radio"/> Portuguese	<input type="radio"/> Vietnamese
<input type="radio"/> Fijian	<input type="radio"/> Japanese	<input type="radio"/> Russian	<input type="radio"/> Xiang Chinese
<input type="radio"/> Formosan (Amis)	<input type="radio"/> Korean	<input type="radio"/> Samoan	<input type="radio"/> Yiddish
<input type="radio"/> French	<input type="radio"/> Lao	<input type="radio"/> Scandinavian Languages	<input type="radio"/> Yoruba
<input type="radio"/> French Creole	<input type="radio"/> Lu-Mien	<input type="radio"/> Serbian	
<input type="radio"/> German	<input type="radio"/> Mandarin	<input type="radio"/> Spanish	<input type="radio"/> Other (not listed)
<input type="radio"/> Greek	<input type="radio"/> Other Chinese	<input type="radio"/> Swahili	
<input type="radio"/> Gujarati	<input type="radio"/> Other Non-English	<input type="radio"/> Tagalog	<input type="radio"/> Decline to State

Gender ☐ Yes ☐ No

[illegible]



California State Board of Pharmacy

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Fax (916) 574-8618
www.pharmacy.ca.gov

STATE AND CONSUMER SERVICES AGENCY
DEPARTMENT OF CONSUMER AFFAIRS
GOVERNOR EDMUND G. BROWN JR.

Date: March 4, 2011

To: Licensing Committee

**Subject: Agenda Item 7-
Emergency Preparedness**

At the Annual Meeting of the California Pharmacists Association in February, the executive officer was contacted by the California Emergency Medical Services Authority (EMSA) and asked for an opportunity to address the board on emergency preparedness.

Mr. Patrick Lynch, Manager of the Response Personnel Unit of EMSA, will provide a presentation at this meeting on current state policies on emergency response.

One item of note, of 39,480 licensed pharmacists in California, only about 400 pharmacists are registered with EMSA.

As background, a copy of the board's highly evolved emergency response policy follows this page. Also attached is an EMSA brochure.

Disaster Response Policy Statement

Advance planning and preparation for disaster and emergency response are important activities for individuals, as well as all Board licensees. The Board has begun working on such preparedness with the federal and state government, and to this end, in October 2006, the Board adopted the following policy statement.

The California State Board of Pharmacy wishes to ensure complete preparation for, and effective response to, any local, state, or national disaster, state of emergency, or other circumstance requiring expedited health system and/or public response. The skills, training, and capacities of board licensees, including wholesalers, pharmacies, pharmacists, intern pharmacists, and pharmacy technicians, will be an invaluable resource to those affected and responding. The Board also wishes to encourage an adequate response to any such circumstance affecting residents of California, by welcoming wholesalers, pharmacies, pharmacists, intern pharmacists, and pharmacy technicians licensed in good standing in other states to assist with health system and/or public response to residents of California.

The Board encourages its licensees to volunteer and become involved in local, state, and national emergency and disaster preparedness efforts. City or county health departments, fire departments, or other first responders can provide information on local opportunities. The Emergency Preparedness Office of the California Department of Health Services is a lead agency overseeing emergency preparedness and response in California, particularly regarding health system response, drug distribution and dispensing, and/or immunization and prophylaxis in the event of an emergency. At the federal level, lead contact agencies include the Department of Health and Human Services, the Centers for Disease Control, and/or the Department of Homeland Security and its Federal Emergency Management Agency (FEMA). Potential volunteers are encouraged to register and get information at www.medicalvolunteer.ca.gov (California) and www.medicalreservercorps.gov (federal).

The Board also continues to be actively involved in such planning efforts, at every level. The Board further encourages its licensees to assist in any way they can in any emergency circumstance or disaster. Under such conditions, the priority must be protection of public health and provision of essential patient care by the most expeditious and efficient means. Where declared emergency conditions exist, the Board recognizes that it may be difficult or impossible for licensees in affected areas to fully comply with regulatory requirements governing pharmacy practice or the distribution or dispensing of lifesaving medications.

In the event of a declared disaster or emergency, the Board expects to utilize its authority under the California Business and Professions Code, including section 4062, subdivision (b) thereof, to encourage and permit emergency provision of care to affected patients and areas, including by waiver of requirements that it may be implausible to meet under these circumstances, such as prescription requirements, record-keeping requirements, labeling requirements, employee ratio requirements, consultation requirements, or other standard pharmacy practices and duties that may interfere with the most efficient response to those affected. The Board encourages its licensees to assist, and follow directions from, local, state, and national health officials. The Board expects licensees to apply their judgment and training to providing medication to patients in the best interests of the patients, with circumstances on the ground dictating the extent to which regulatory requirements can be met in affected areas. The Board further expects that during such emergency, the highest standard of care possible will be provided, and that once the emergency has dissipated, its licensees will return to practices conforming to state and federal requirements.

Furthermore, during a declared disaster or emergency affecting residents of California, the Board hopes that persons outside of California will assist the residents of California. To facilitate such assistance, in the event of a declared California disaster or emergency, the Board expects to use its powers under the California Business and Professions Code, including section 900 and section 4062, subdivision (b) thereof, to allow any pharmacists, intern pharmacists, or pharmacy technicians, who are not licensed in California but who are licensed in good standing in another state, including those presently serving military or civilian duty, to provide emergency pharmacy services in California. The Board also expects to allow nonresident pharmacies or wholesalers that are not licensed in California but that are licensed in good standing in another state to ship medications to pharmacies, health professionals or other wholesalers in California.

Finally, the Board also expects to allow use of temporary facilities to facilitate drug distribution during a declared disaster or state of emergency. The Board expects that its licensees will similarly respond outside of the state to disasters or emergencies affecting populations outside California, and will pursue whatever steps may be necessary to encourage that sort of licensee response.

¹Expanded powers in the event of a disaster are also granted to the Governor and/or other chief executives or governing bodies within California by the California Emergency Services Act [Cal. Gov. Code, §§ 8550-8668] and the California Disaster Assistance Act [Cal. Gov. Code, §§ 8680-8690.7], among others. Section 8571 of the Government Code, for instance, permits the Governor to suspend any regulatory statute during a state of war or emergency where strict compliance therewith would prevent, hinder, or delay mitigation.

²See also the Interstate Civil Defense and Disaster Compact [Cal. Gov. Code, §§ 177-178], the Emergency Management Assistance Compact [Cal. Gov. Code, §§ 179-179.5], and the California Disaster and Civil Defense Master Mutual Aid Agreement [executed 1950], regarding cooperation among the states.

Volunteer Questions and Answers:

Q: Is there protection for liability and workers compensation for volunteer health professionals?

A: Volunteers deployed through Disaster Healthcare Volunteers will be registered in their local county as Disaster Service Workers, a program providing these protections.

Q: Do I need to have prior disaster experience?

A: No! All volunteers are welcome.

Q: I'm retired. Can I still volunteer?

A: Yes! Just be sure to indicate your license status when you register.

Q: What other issues should I consider?

A: Care for your family if you respond. Emergency response can be physically and emotionally difficult; personal medical conditions may need to be evaluated. You may have work or other commitments that would prevent you from responding to an activation. Missions may be up to ten days in duration.



Who Should Register?

- Audiologists and Audiology Aides
- Certified Nurse Assistants
- Chiropractors
- Clinical Laboratory Scientists
- Medical Laboratory Technologists
- Clinical Nurse Specialists
- Cytotechnologists
- Dentists
- Diagnostic Radiologic Technologists
- EMT-Is and EMT-Paramedics
- Hemodialysis Technicians
- Home Health Aides
- Licensed Clinical Social Workers
- Licensed Midwives
- Licensed Vocational Nurses
- Marriage and Family Therapists
- Nuclear Medicine Technologists
- Nurse Anesthetists
- Nurse Midwives
- Nurse Midwife Furnishers
- Nurse Practitioner Furnishers
- Nurse Practitioners
- Occupational Therapists
- Occupational Therapy Assistants
- Optometrists
- Osteopathic Physicians and Surgeons
- Pharmacists
- Pharmacy Technicians
- Phlebotomists
- Physical Therapists
- Physical Therapist Assistants
- Physicians and Surgeons
- Physician Assistants
- Podiatrists
- Psychiatric Mental Health Nurses
- Psychiatric Technicians
- Psychologists
- Public Health Microbiologists
- Public Health Nurses
- Registered Associate Social Workers
- Registered Dental Assistants
- Registered Dental Hygienists
- Registered Nurses
- Registered Veterinary Technicians
- Respiratory Care Practitioners
- Speech-Language Pathologists
- Speech-Language Pathology Aides
- Veterinarians

*Managed by the California Emergency Medical Services Authority,
in partnership with the California Department of Public Health.
Funds are provided by the United States
Department of Health and Human Services.*

California Emergency Medical Services Authority
1930 9th Street • Sacramento, CA 95811
Phone: 916-322-4336 • Fax: 916-323-4898
Email: healthcarevolunteers@ems.ca.gov
Web: <http://www.emsa.ca.gov>

WHEN DISASTER STRIKES, YOU CAN MAKE THE DIFFERENCE



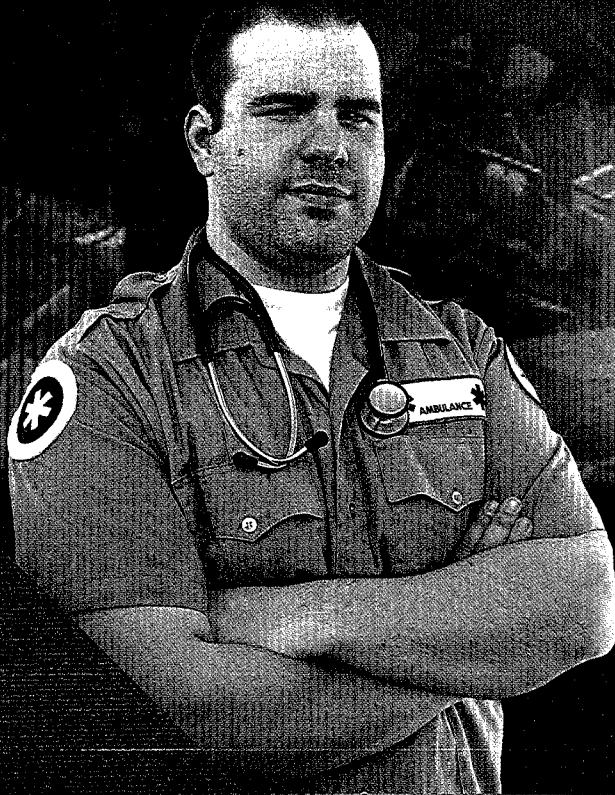
REGISTER TODAY

WWW.HEALTHCAREVOLUNTEERS.CA.GOV

WWW.HEALTHCAREVOLUNTEERS.CA.GOV

Who are "Disaster Healthcare Volunteers?"

Disaster Healthcare Volunteers are professionals like you who want to volunteer during an emergency or disaster. When you register on our secure web-based registry, you will indicate your volunteer preferences and enter information about your skills. The registry will automatically notify you in the case of a disaster and track your deployment.



What role will I have in a large-scale disaster or emergency?

Your role will be to practice your profession or skill as either an individual called up at the time of a disaster, or as part of an organized response team. Volunteers may participate in several ways, including:

- As an individual called upon during extreme emergencies for your county
- As part of a community-based Medical Reserve Corps;
- As a member of a State of California Medical Assistance Team.

Every attempt will be made to match your skills, competencies and license or registration level with your responsibilities during a disaster. However, there might be situations in which you will be asked to assist with activities that are less challenging than your normal work duties.

How do I register?

Visit the Disaster Healthcare Volunteers' site at: **WWW.HEALTHCAREVOLUNTEERS.CA.GOV**, click the "Register Now" button and you're on your way!

How does the "Disaster Healthcare Volunteers" program work?

Once you have registered to become a Disaster Healthcare Volunteer, your professional license will be verified electronically with your licensing board by the Emergency Medical Services Authority. This information will become a part of the secure Disaster Healthcare Volunteer Statewide Registry.

During a disaster, state or local (county) officials will determine what kind of health professionals are needed, search the database for available volunteers, and send an alert to selected members via e-mail, telephone and pager.

If you receive an alert in the event of a disaster, you will have the chance to accept or decline the volunteer request. If you accept, you will receive specific instructions on where and when to report, and what is needed for the incident. There is no obligation to participate during an activation.

Why register now, before a disaster?

Registering now allows verification of your license and credentials, promotes training opportunities, and helps disaster managers understand how many volunteers might be available. This will help us match your skills with the needs required in each emergency situation.

Registering now makes it easier to help when disaster strikes!

REGISTERING IS EASY!

Visit the Disaster Healthcare Volunteers' site at: **WWW.HEALTHCAREVOLUNTEERS.CA.GOV**, click the "Register Now" button and you're on your way!

**IN TIMES OF DISASTER, CALIFORNIA NEEDS YOU!
BECOME A DISASTER HEALTHCARE VOLUNTEER
REGISTER TODAY AT WWW.HEALTHCAREVOLUNTEERS.CA.GOV**



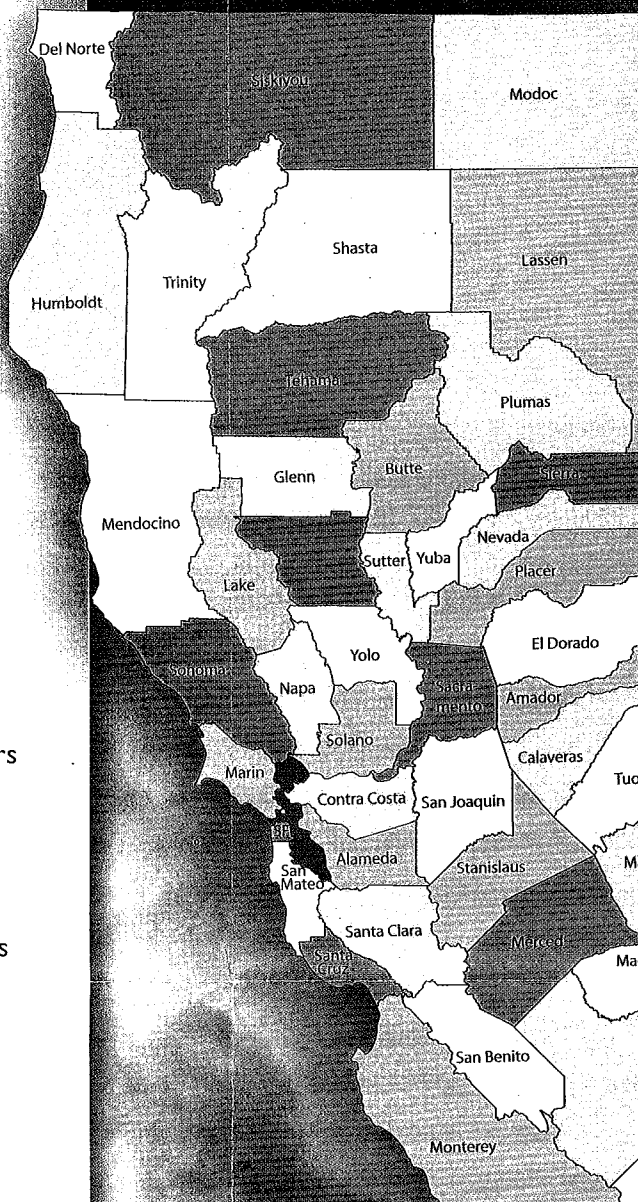
BECOME A DISASTER HEALTHCARE VOLUNTEER

REGISTER TODAY AT WWW.HEALTHCAREVOLUNTEERS.CA.GOV



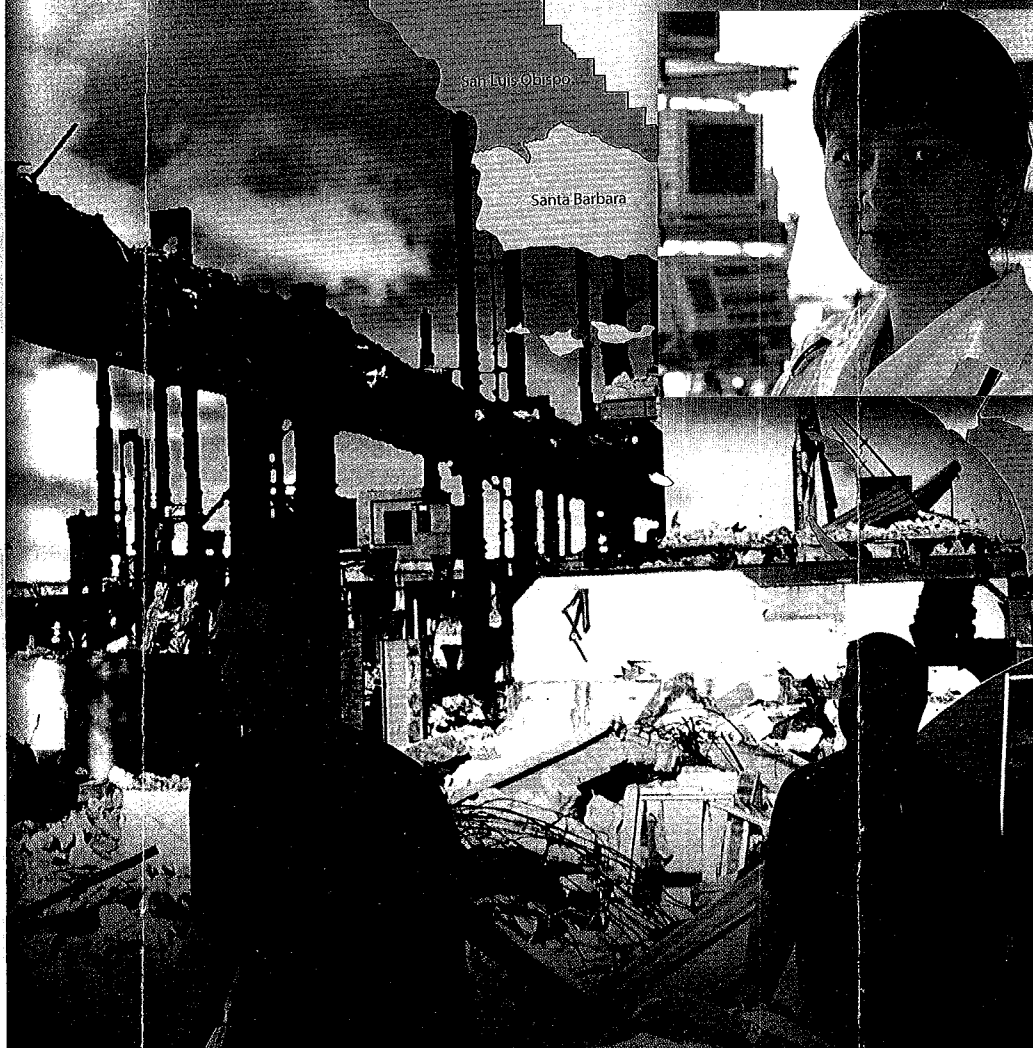
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- Marriage and Family Therapists
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- Nurse Anesthetists
- Nurse Midwives
- Nurse Midwife Furnishers
- Nurse Practitioner Furnishers
- Nurse Practitioners
- Occupational Therapists
- Occupational Therapy Assistants
- Optometrists
- Osteopathic Physicians and Surgeons
- Pharmacists
- Pharmacy Technicians
- Phlebotomists
- Physical Therapists
- Physical Therapist Assistants
- Physicians and Surgeons
- Physician Assistants
- Podiatrists
- Psychiatric Mental Health Nurses
- Psychiatric Technicians
- Psychologists
- Public Health Microbiologists
- Public Health Nurses
- Registered Associate Social Workers
- Registered Dental Assistants
- Registered Dental Hygienists
- Registered Nurses
- Registered Veterinary Technicians
- Respiratory Care Practitioners
- Speech-Language Pathologists
- Speech-Language Pathology Aides
- Veterinarians



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California State Board of Pharmacy

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STATE AND CONSUMERS SERVICES AGENCY
DEPARTMENT OF CONSUMER AFFAIRS
GOVERNOR EDMUND G. BROWN JR.

Date: March 3, 2011

To: Licensing Committee

Subject: Competency Committee Report

Both Competency Committee workgroups have meetings scheduled in the spring of 2011 to work on examination development. The Competency Committee will ensure the new outline will be used to develop examinations administered after April 1, 2011.

Board staff has updated the CPJE Candidate Information Bulletin and board Web site to reflect the new content outline as well as notified candidates eligible to take the CPJE of the change.



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STATE AND CONSUMERS SERVICES AGENCY
DEPARTMENT OF CONSUMER AFFAIRS
GOVERNOR EDMUND G. BROWN JR.

Date: March 3, 2011

To: Licensing Committee

Subject: Licensing Statistics

Following this memo are the statistics for licensing workload beginning in July 2010. As of March 1, 2011, the board has received over 11,300 applications for licensure; almost 6,800 are seeking licensure as a pharmacy technician. The board has issued over 9,800 new licenses and processed about 1,270 change applications (e.g. change in pharmacist-in-charge, change of permits, etc.) The board has about 4,900 applications pending, a portion of these applications are awaiting receipt of deficient items and almost 800 are eligible pharmacist exam applicants that have not taken the exam.

Board of Pharmacy Licensing Statistics - Fiscal Year 2010/11

	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUN*	FYTD
APPLICATIONS													
Received													
Pharmacist (exam applications)	137	102	132	152	118	101	84	94					920
Pharmacist (initial licensing applications)	203	343	169	184	87	68	25	136					1215
Intern pharmacist	50	472	381	341	41	52	94	68					1499
Pharmacy technician	776	955	870	930	776	886	831	759					6783
Pharmacy	19	28	28	22	27	23	20	20					187
Pharmacy - Temp	10	5	10	25	15	9	8	2					84
Sterile Compounding	5	4	4	8	9	3	4	5					42
Sterile Compounding - Temp	0	0	0	0	5	2	0	0					7
Clinics	4	2	8	8	0	3	8	7					40
Hospitals	6	0	0	17	10	1	2	0					36
Hospitals - Temp	0	0	0	0	0	0	0	0					0
Nonresident Pharmacy	4	8	5	8	4	9	7	3					48
Nonresident Pharmacy - Temp	0	0	0	2	0	1	2	0					5
Licensed Correctional Facility	0	0	0	0	0	0	0	0					0
Hypodermic Needle and Syringes	2	2	3	1	1	1	1	2					13
Nonresident Wholesalers	10	11	9	7	10	13	6	10					76
Nonresident Wholesalers - Temp	0	0	2	3	0	1	1	0					7
Wholesalers	7	9	6	3	9	3	4	4					45
Wholesalers - Temp	0	1	0	0	0	0	0	0					1
Veterinary Food-Animal Drug Retailer	0	0	0	0	0	0	0	0					0
Veterinary Food-Animal Drug Retailer - Temp	0	0	0	0	0	0	0	0					0
Designated Representatives	36	42	39	49	25	32	43	32					298
Total	1269	1984	1666	1760	1137	1208	1140	1142	0	0	0	0	11306

Board of Pharmacy Licensing Statistics - Fiscal Year 2010/11

	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUN*	FYTD
Issued													
Pharmacist	179	471	77	267	85	90	13	124					1306
Intern pharmacist	72	310	544	333	65	53	80	50					1507
Pharmacy technician	752	932	794	789	778	1042	383	858					6328
Pharmacy	21	18	23	17	28	26	25	26					184
Pharmacy - Temp	0	0	0	0	0	0	0	0					0
Sterile Compounding	3	1	1	3	3	10	3	2					26
Sterile Compounding - Temp	0	0	0	0	0	0	0	0					0
Clinics	9	6	3	1	3	5	7	4					38
Hospitals	1	2	0	3	7	10	10	3					36
Hospitals - Temp	0	0	0	0	0	0	0	0					0
Nonresident Pharmacy	4	0	10	6	4	6	4	8					42
Nonresident Pharmacy - Temp	0	0	0	0	0	0	0	0					0
Licensed Correctional Facility	0	0	0	0	0	0	1	0					1
Hypodermic Needle and Syringes	2	0	2	2	1	1	0	2					10
Nonresident Wholesalers	4	3	4	7	14	6	3	12					53
Nonresident Wholesalers - Temp	0	0	0	0	0	0	0	0					0
Wholesalers	4	6	6	0	6	4	0	8					34
Wholesalers - Temp	0	0	0	0	0	0	0	0					0
Veterinary Food-Animal Drug Retailer	0	0	0	0	0	0	0	0					0
Veterinary Food-Animal Drug Retailer - Temp	0	0	0	0	0	0	0	0					0
Designated Representatives	16	29	41	44	35	17	48	29					259
Total	1067	1778	1505	1472	1029	1270	577	1126	0	0	0	0	9824
Pending													
Pharmacist Examination	725	566	622	605	498	487	384	356					605
Pharmacist Examination Eligible	1043	1043	979	799	825	760	744	629					799
Intern pharmacist	270	441	274	276	243	241	134	151					276
Pharmacy technician	2505	2550	2697	2693	2751	2465	2698	2585					2693
Pharmacy	75	81	85	90	86	80	65	58					90
Sterile Compounding	24	26	26	29	34	28	21	22					29
Clinics	29	26	23	28	26	24	26	28					28
Hospitals	8	8	6	13	23	13	4	4					13
Nonresident Pharmacy	43	51	40	44	44	46	47	42					44
Licensed Correctional Facility	0	0	0	0	0	0	0	0					0
Hypodermic Needle and Syringes	12	15	12	11	11	11	9	8					11
Nonresident Wholesalers	78	86	74	72	69	76	68	66					72
Wholesalers	48	49	47	48	52	52	51	48					48
Veterinary Food-Animal Drug Retailer	0	0	0	0	0	0	0	0					0
Designated Representatives	188	197	180	175	163	181	153	158					175
Total	5048	5139	5065	4883	4825	4464	4404	4155	0	0	0	0	4883

Board of Pharmacy Licensing Statistics - Fiscal Year 2010/11

	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUN*	FYTD
Change of Pharmacist-in-Charge***													
Received	104	128	102	154	108	106	84	82					868
Processed	118	132	99	136	123	90	60	76					834
Pending	389	385	388	381	366	463	487	493					381
Change of Exemptee-in-Charge***													
Received	8	9	6	12	8	12	13	6					74
Processed	4	0	7	0	0	0	0	9					20
Pending	108	117	116	128	136	148	161	158					128
Change of Permits													
Received	48	69	54	43	59	53	67	46					439
Processed	4	44	15	39	38	159	74	44					417
Pending	222	247	286	303	324	218	211	213					303
Discontinuance of Business***													
Received	20	21	10	24	17	78	n/a	1					171
Processed	0	0	28	1	0	78	0	2					109
Pending	135	156	138	162	179	179	179	178					162
Renewals Received	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY*	JUN*	FYTD
Pharmacist	1572	1339	3322	2317	1052	1696	1455						12753
Pharmacy technician	2958	2262	4676	2504	1875	2595	2219						19089
Pharmacy	407	298	633	960	226	692	329						3545
Sterile Compounding	26	17	76	39	23	30	13						224
Clinics	106	68	145	91	47	80	92						629
Nonresident Pharmacy	31	20	70	18	18	27	21						205
Licensed Correctional Facility	0	0	27	17	2	0	0						46
Hypodermic Needle and Syringes	17	10	50	28	23	33	18						179
Nonresident Wholesalers	56	43	86	35	43	33	39						335
Wholesalers	73	27	91	27	37	42	31						328
Veterinary Food-Animal Drug Retailer	2	1	5	1	3	4	2						18
Designated Representative	155	113	416	179	170	255	184						1472
Total	5403	4198	9597	6216	3519	5487	4403	0	0	0	0	0	38823